

Hartlepool

Integration and Better Care Fund Plan

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

Contents

1.	Introduction / Foreword	3
2.	The Local Vision and Approach for Health and Social Care Integration	4
3.	Background and Context.....	10
4.	Progress to Date.....	17
5.	Evidence Base and Local Priorities to Support Plan for Integration.....	27
6.	Better Care Fund Plan 2017-2019.....	30
7.	Use of IBCF.....	34
8.	Use of DFG Funding.....	36
9.	Risk.....	37
10.	Overview of Funding Contributions	42
11.	Programme Governance.....	43
12.	National Metrics	45
13.	Approval and Sign Off	47
14.	Key Lines of Enquiry.....	48
	Appendix 1	54

1. Introduction / Foreword

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

The agreed priorities for 2017-2019 are:

- New Models of Care
- Integrated Hospital Discharge
- Integrated Intermediate Care
- Integrated Single Point of Access
- Care Quality Improvement Programme

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

Funding	2017/18	2018/19
CCG Minimum Contribution	£6,819,287	£6,948,857
Disabled Facilities Grant	£930,517	£997,971
IBCF Allocation	£2,707,874	£3,737,159
TOTAL	£10,457,769	£11,683,987

The BCF Schemes are outlined in more detail throughout the narrative plan outlining the BCF Plan for 2017/19 from page 31 and planning documents.

[Agreed outcomes linked to the Better Care Fund Plan for 2017/19:](#)

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

The Hartlepool Health & Wellbeing Board is responsible for; signing off and ensuring delivery on the Hartlepool Better Care Fund Plan; ensuring that the BCF plan responds to local needs, is aligned with the Health & Wellbeing Strategy and supports system integration across health and social care; agreeing the use of funding under the Better Care Fund pooled budget arrangements; addressing any risks and issues arising that relate to the wider Hartlepool health and social care system; and progressing any joint commissioning implications and requirements arising from the Better Care Fund.

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

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

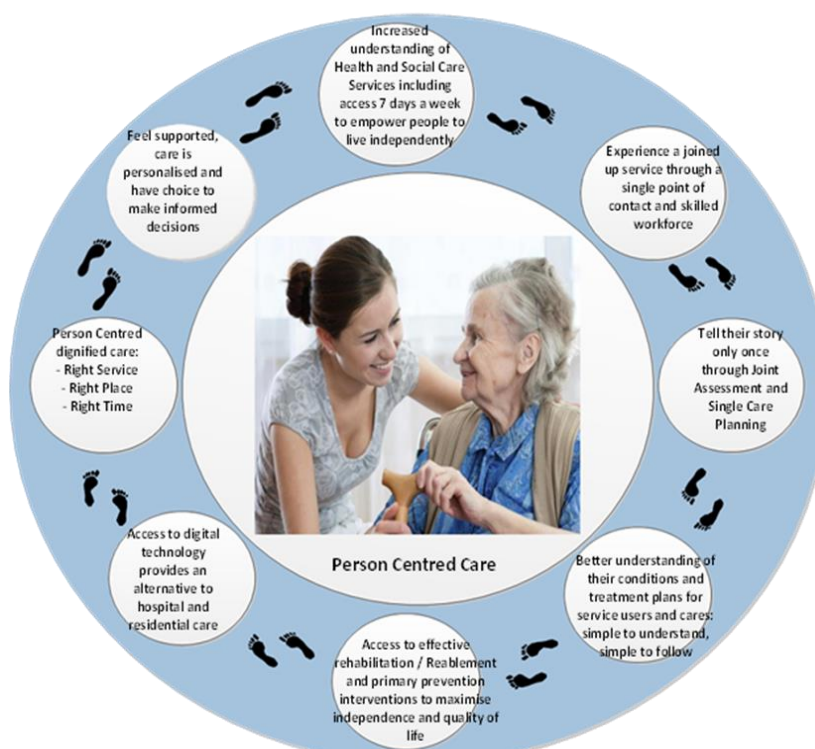
Vision - "Meeting people's needs now and future proofing for the coming generation with consistently better integrated health and social care delivered in the best place"

The vision is that by 2020 everyone is able to live at home longer, be healthier and get the right support where required, whether this be provided by health or social care. The focus will be on integrated health and social care, primary prevention, early diagnosis and intervention and supported self-management with the aim of closing the health and wellbeing gap and reducing health inequalities as well as driving transformation to close the care and quality gap.

Residents of Hartlepool deserve the best possible 'joined up' health and social care and should get the right care, in the right place, at the right time, supporting them to have longer, healthier lives. People should be able to say "I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me" *Integrated Care and Support: Our Shared Commitment: 2013*).

This is why partners across health and care services have been working together to deliver the system vision described in the BCF plan, including a sustained focus on integration to 'create services that maximise health and wellbeing and address individual needs, improving outcomes and experiences for individuals and communities'. The person is firmly at the centre of our plans, and pathways will continue to be designed to maintain this (Diagram 1.)

Diagram 1



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

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

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

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

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

Sustainability and Transformation

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

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

Delivery models in 2017 - 2022:

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

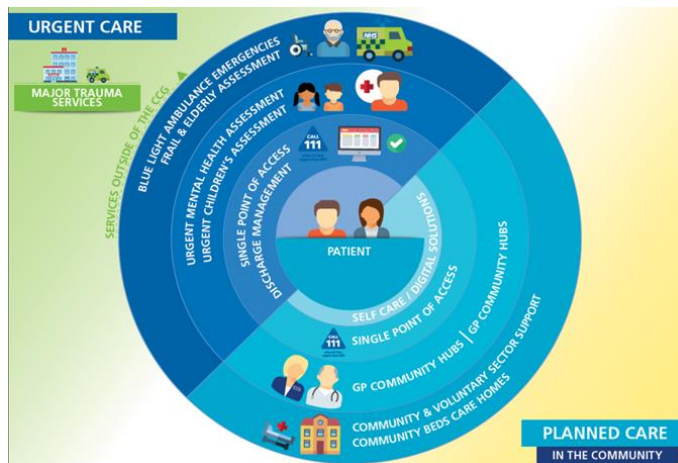
New Models of Care

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

The diagram below demonstrates how primary care will become integrated into the identified model and services will transition to community hub settings, through physical or virtual delivery models with the overall focus of the Multi-Speciality Community Provider (MCP)

model being early intervention and prevention with one focussed Single Point of Access supporting a number of hubs across Hartlepool and Stockton-on-Tees.

Diagram 2



Local Models of Care

The STP outlines the following local developments in Hartlepool and Stockton-on-Tees that will drive forward partnership working across health and social care services:

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

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

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

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

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

The BCF plan builds on services commissioned and developed over a number of years and has interdependencies with wider plans across health and social care, including Hartlepool Matters, Hartlepool Joint Health and Wellbeing Strategy and Local A&E Delivery Board Plans.

[Hartlepool Matters](#)

[Health & Wellbeing Strategy](#)

[Annual DPH Report 2017 – Ageing Well](#) (part of the Health and Wellbeing Board papers)

[Market Position Statement](#)

[STP](#)

[CCG Operational Plan](#)

Support for Previous National Conditions

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

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

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

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

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

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

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

A joint approach to assessments and care planning: the care co-ordination model within primary care is based on risk stratification and frailty scores and aims to target multi professional resources at those people who would potentially benefit the most from proactive intervention that supports admission avoidance. The Integrated Discharge Team joins up assessment and care planning for people when they are ready to be discharged from hospital. Ongoing care co-ordination is provided to people who have eligible social care needs and require a longer term package of support through locality care management teams that are co-located with community nursing Teams Around the Practice and work in partnership with the Intensive Community Liaison Service and Community Mental Health Teams for Older People to support people with dementia in care homes and in the community.

Agreed Outcomes of the BCF Plan:

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

3. Background and Context

Key Issues and Challenges

The health and social care economy in Hartlepool faces a range of significant challenges:

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

Hartlepool is one of the most deprived areas in Britain and faces significant demographic challenges in terms of deprivation as well as an ageing population and an increasing number of people with disabilities. Tackling health inequalities caused due to: lack of income; where people live; or by any other potential disadvantage, including people with protected characteristics under the Equality Act 2010, remains a priority.

Detailed information regarding demographic challenges can be found in the Joint Strategic Needs Assessment. Some of the key facts that outline the challenge for adult health and social care services in relation to older people include:

- Healthy life expectancy for both men and women is lower than the national average.
- Health-related quality of life for older people is significantly lower than the national average.
- Higher than average rates of limiting long term illness and health problems.
- An increasing population of over 65s and over 85s - by 2025, over a quarter of the local population will be over 65 years of age.
- Increasing prevalence of dementia and depression in older people.
- A higher rate of older people living alone than the national average.
- Higher rates of deaths for over 65s from cardiovascular disease, respiratory disease and cancer than national and regional averages.
- Higher than average rate of people living in fuel poverty.

An Ageing Population:

People are living longer and, whilst the increase in life expectancy is welcomed, this presents challenges for health and social care services as people living longer often have complex health conditions and require significant levels of support to remain independent.

Research shows that older age is associated with an increased incidence of multiple long term conditions and a growing number of functional and cognitive impairments. It is estimated that 58% of those aged 60 and over report having a Long Term Condition (LTC) with 25% of over 60s having two or more LTCs. For Hartlepool this would mean that by 2020 there will be approximately 4,700 over 65s with two or more LTCs.

The number of older people who are living alone is increasing at the same time as informal support networks from families are declining, which significantly increases the risk of social isolation and loneliness. It is estimated that 35.5% of over 65s in Hartlepool live alone.

The number of people living with dementia is also expected to increase significantly. Data indicates that in 2014 1,193 older people in Hartlepool were predicted to have dementia (6.9%). This is predicted to rise to 1,358 people by 2020 (7.2%) and 1,811 people by 2030 (7.8%).

These trends have resulted in a growing demand for health services to treat multiple long term conditions as well as care services to help individuals cope with everyday activities such as dressing, bathing, shopping or preparing food.

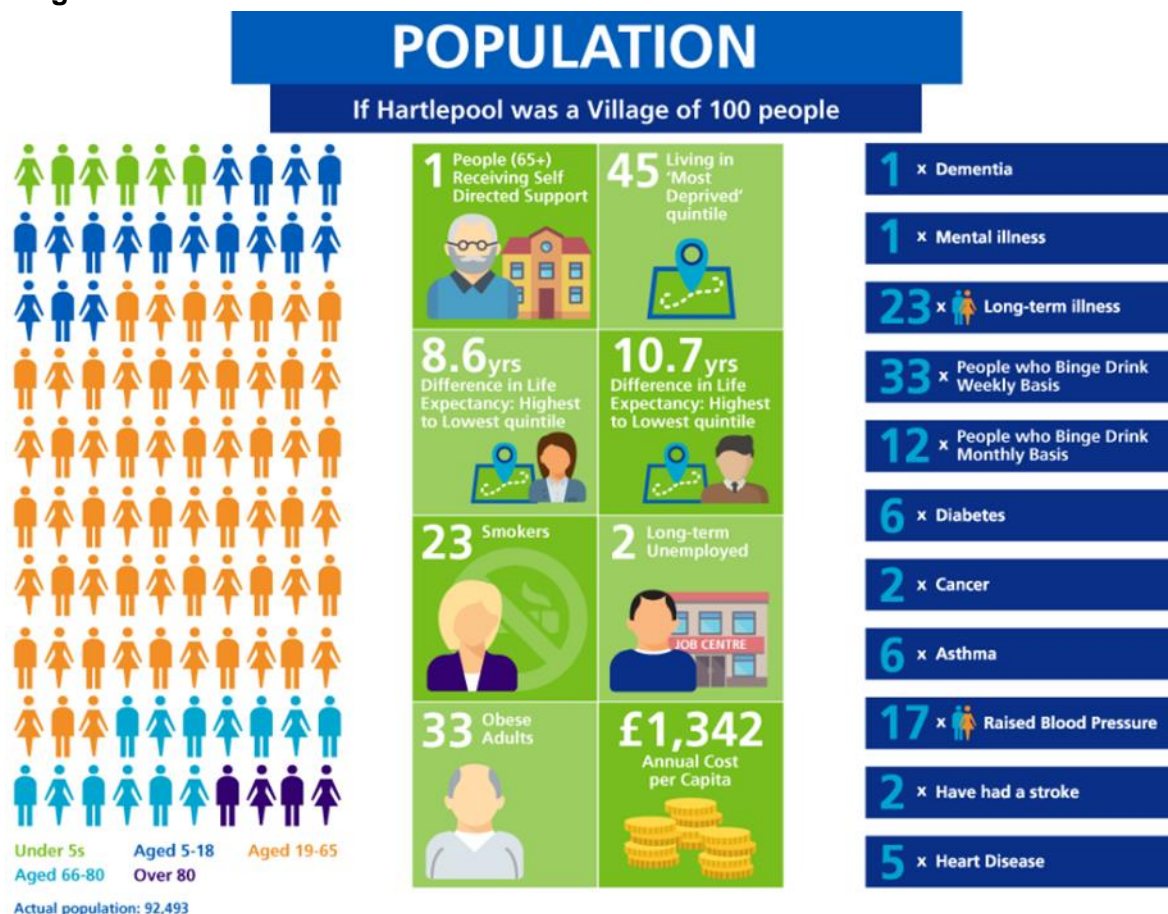
Given the ageing population and associated levels of need for health services, this growth in demand is expected to increase significantly over the next 5-10 years if services continue to support people in the current way. The demand on social care services and particularly long term care is also predicted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

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

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

Diagram 3 illustrates the prevalence of long term conditions and demand for health and social care if Hartlepool was a village of 100 people.

Diagram 3



Wider Determinants of Health:

As the Marmot Review made clear, a person's health and wellbeing in later life is affected by a wide range of determinants such as poverty, housing, employment and education, as well as healthy lifestyles and health care. The Hartlepool Better Care Fund Plan recognises these wider determinants of health and promotes earlier intervention through a more holistic approach to care planning, which incorporates low level services, early intervention and prevention, housing issues, social isolation and healthy lifestyle issues.

Workforce Challenges

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

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

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

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

Actions being taken include:

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

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

The most significant pressure within adult social care relates to commissioned services and specifically the recruitment and retention of qualified nursing staff within care home settings. This issue has impacted on quality of care in some local homes in recent years and has ultimately affected ongoing viability of some services. A number of care homes have ceased to operate locally in recent years, or ceased to provide nursing care, citing recruitment and retention of nurses as one of the factors influencing this outcome.

Recruitment and retention of care staff is also a challenge for some providers in relation to turnover and the provision of development opportunities / career pathways within the care sector. Current work with local Further Education providers to explore the development of a Care Academy aims to tackle these issues.

Market Challenges

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

Local authorities are also required to engage with local providers, to help each other understand what services are likely to be needed in the future, and what new types of support should be developed.

There is a varied market in Hartlepool in relation to services for older people, with investment in extra care provision over many years to provide alternatives to residential care, continued growth in the use of assistive technology and a range of low level services that promote independence, including signposting and advice, a handyperson service, lunch clubs, carers support and support for people with dementia and their carers / families.

The Council has positive relationships with care providers and engages regularly through provider forums. A Market Position Statement sets out the key drivers for the Council, the current position, what is important to local people and commissioning intentions. The key issue in relation to older people over the last two years has been a significant shortage in nursing home capacity, following the closure of a number of homes. This position had a significant impact on delayed transfers of care during 2016/17 as people remained in hospital, sometimes for many weeks, awaiting their home of choice and others chose to move to nursing homes outside of the Council area. The situation has since improved with a new care home becoming operational in May 2017 and further developments planned during 2017/18, but remain fragile. There have also been issues with the quality of care in some services over the past year, and a range of actions are in place to drive quality improvements including education and training for care homes, enhanced pharmacy support for providers, the Council's Quality Standards Framework, the CCG Clinical Quality Assessment process and regular forums for care home managers to share best practice.

The same pressures have not been felt to date in relation to homecare provision, which has been relatively stable for the last two years. Services will be re-procured during 2017 with a drive to improve quality through incorporation of the Unison Ethical Care Charter standards within the new contracts and inclusion of the telecare response and carers emergency respite support within the specification, which will improve continuity and consistency for

people using services, enabling the Council provision to focus solely on intermediate care and reablement.

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

- There has been a 16% increase in spending on CHC between 2013/14 and 2015/16
- 4% of CCG spend is accounted for by CHC
- £5.247m expected spend on CHC, NHS funded nursing care and assessment costs by 2020/21 if no action is taken (an increase from £3.60m in 2015/16).

Performance

There are a range of areas where Hartlepool performs very well in relation to health and social care (including the proportion of people supported by direct payments, user and carer satisfaction, and proportion of older people who report they have as much social contact as they would like. The CCG received a 'good' rating from NHS England through the Improvement and Assessment Framework (IAF) Assurance Process and from the clinical priority areas identified through the IAF, the CCG received an outstanding rating for overall dementia assessment. However, there are also areas where there are currently some significant challenges.

Data from the NHS/Social Care Interface Dashboard is summarised below:

Metric	Rank
Emergency Admissions (65+) per 100,000 65+ population	119 of 151
Length of stay for Emergency Admissions (65+)	123 of 151
Total Delayed Days per day per 100,000 18+ population	114 of 151
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	88 of 151
Proportion of older people (65 and over) who are discharged from hospital who receive reablement/ rehabilitation services	93 of 151
Proportion of discharges (following emergency admissions) which occur at the weekend	138 of 151

Overall, Hartlepool is ranked 147 of 151 Local Authorities based on these indicators.

Resource Challenges

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

From a social care perspective, by 2019/20 Government funding will have been cut for nine years. The Medium Term Financial Strategy approved by Hartlepool Borough Council in February 2017 set out that the Council faced a gross budget deficit over the next three years of £20.8m. The implementation of corporate savings, forecast Council Tax increases,

housing growth and increased Better Care Funding reduces this to £8.8 million over the next three years, which equates to 10% of the 2016/17 budget. Detailed savings proposals totalling approximately £6.6m were approved by Council at the same meeting, which means further savings of £2.2m still need to be achieved over the next three years. This figure may increase if existing budget pressures cannot be managed by reducing demand for demand led services.

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

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

Demand for health care services increases every year. In Hartlepool, there were 5,201 emergency admissions to hospital for people aged over 65 in 2016/17, in 2015/16 this was 4825, therefore has increased by 8%. In addition the range of services offered has changed significantly in recent years with some services that were traditionally provided by hospitals now being delivered in the community. There is an increasing need for an integrated approach to the management of patients, particularly those with long term and complex conditions.

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

4. Progress to Date

The BCF plan for 2016/17 was jointly developed and common aims were agreed:

- To ensure that the population of Hartlepool has access to a wide range of primary prevention interventions.
- To maximise independence and quality of life and help people to stay healthy and well through the development of integrated community health and social care services with a focus on long term conditions, frail elderly (including end of life) and dementia. This will be delivered through the roll out of an integrated care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary working.
- To streamline care and reduce activities that are carried out by multiple organisations ensuring the right services are available in the right place, at the right time through an integrated community approach providing rapid response to support individuals to remain at home and avoid admission.
- To improve people's experience of services through the introduction of a single point of access across health and social care, utilising the NHS number.
- To improve outcomes for service users and carers through clearer and simpler care pathways and proactive management of people with long term conditions.
- To have a skilled workforce that understands both the health and social care system and works across organisational boundaries, making every contact count.
- To ensure that each person has a package of care that improves their physical, social and emotional wellbeing, acknowledging that all three elements are necessary to enjoy good health.
- To support personalisation and choice by being able to develop a range of coordinated alternatives to hospital and residential care, this will be delivered through investment in personalised health and care budgets ensuring individuals are able to make informed decisions.
- To ensure that digital technology is utilised innovatively to deliver the greatest possible benefit to people using services and carers across health and social care services.
- To improve access to community health and social care services 7 days a week to improve user experience and provide responsive services in and out of hours, reduce delayed discharges and improve support to empower people to live independently.

The 2016/17 plan identified key priorities in relation to:

Enhanced Early Intervention Model (EIM)

The enhanced Early Intervention Model has an increased focus on prevention of hospital and care home admissions through proactive partnership working between health and social care services. New approaches have been piloted with the largest GP practice in Hartlepool initially linked to the 2% Direct Enhanced Service (DES) and frailty register, and the Care Co-ordination pilot commissioned through the A&E Delivery Board.

This model involves health and social care working closely with primary care to determine if further services are required to support people to safely remain at home during a health exacerbation or increased social care need.

The new model incorporates multidisciplinary meetings within GP practices supported by health and social care professionals, to better understand the current provision that supports an individual and where this can be enhanced to prevent the individual from needing an avoidable admission, either to a care home or hospital. These meetings also identify who is the most appropriate professional to support the individual from a care co-ordination perspective.

This approach aims to reduce demand on primary care as well as preventing avoidable admissions to hospital or residential care, by targeting resources effectively and offering a more co-ordinated and targeted package of support to the individual.

Falls Prevention Service

The new service commenced in April 2016 with a team made up of occupational therapy staff from a variety of backgrounds bringing a wide and varied skill set to the service. The primary aim of the service is to offer residents within Hartlepool the opportunity to have access to a falls prevention plan to reduce the risk of falls, either within the home, or the local community.

There are a number of reasons that people fall, which can lead to people not being confident to be a part of their local community and may lead to social isolation or a decline in health and wellbeing. With this in mind adult services and public health have worked closely together to develop a holistic service that looks at the causes of falls, but also provides a vital link to a variety of low level intervention services, giving people the necessary tools to keep safe, keep active and reduce the risk of falls.

To date, over 700 residents who live in their own homes have been screened and over 1,400 people have been provided with their own Falls Prevention Plan.

Further initiatives within the service include supporting all Hartlepool care homes to implement new Falls Prevention documentation and raising awareness of the risk of falls with a 'bottom up approach' (care staff through to management) with staff through a series of on-going training sessions.

Work with Cleveland Fire Brigade

Cleveland Fire Brigade undertake Home Fire Safety Visits in households where vulnerable adults or families live in order to give free fire safety advice and information and supply and fit risk reduction equipment i.e. smoke alarms, free of charge. The project aims to reduce the risk of fire within the home and support vulnerable residents by signposting them to appropriate support agencies to assist in resolving their issues and vulnerabilities. As a result, the Brigade has seen a reduction in accidental dwelling fires, increased fire safety awareness across Cleveland and over 4,000 vulnerable residents are receiving home fire safety visits across Cleveland annually.

The Brigade also supports anyone within Tees Valley who is struggling to stay safe and warm within their own homes. The Stay Safe and Warm campaign aims to deliver emergency heating equipment in the form of portable heaters, thermal blankets, fleecy mattress toppers, electric blankets, wind up lighting units, torches etc giving a holistic assessment of need and onward referrals to agencies for longer term support.

The Brigade has demonstrated an improvement in health and wellbeing both in the short and long term and contributes to the reduction of non-elective hospital admissions due to negative health impacts of living within cold and damp homes. Income maximisation is improved within vulnerable populations and the project is able to identify the more vulnerable residents and refer on for further support, contributing to the wider health and wellbeing agenda.

The Falls Prevention Service has also worked closely with the Fire Brigade across the region devising a Fall Prevention checklist and then delivery various training sessions to Fire Fighters before going live with their agenda for falls in October 2016.

Establishing a Befriending Network

Befriending services have long been viewed as a way of supporting older people to remain living in their own homes for much longer due to increased social contact and additional support with simple tasks around their home. Befriending also helps to reduce loneliness and isolation, which can lead to deterioration in mental well-being. Historically, there have been suggestions that there are people who consider going into residential care because they find it overwhelming to have to deal with their post and daily affairs alone. Therefore, with a small amount of input from a befriender they can be helped to manage living independently for much longer. In addition, GPs have commented that loneliness and isolation can affect an individual's health and hasten the need for hospital or residential care admission, whereas knowing that they will have a regular visitor can improve their mental well-being and give them something to look forward to each week.

A Befriending Network was commissioned by the Council in 2016 to complement a range of existing initiatives that aim to tackle social isolation. The service began in July 2016 and has received 56 referrals to date. There is an ongoing recruitment drive to attract befrienders and a number of positive matches have been made throughout the year which has led to successful outcomes.

Also in 2016 the Council worked with Northgate Community Fund to commission Project 65, a service that supports over 65s to access technology and the internet. This service began

in November 2016 and has received 107 referrals to date. 77 people have been loaned a tablet and 77% of those have gone on to purchase a tablet following the loan period. The average age of those accessing the service is 80 years and 6 months.

Other successes in 2016/17 include:

[Integrated Discharge Team](#)

An Integrated Discharge Team (IDT) has been developed bringing together a range of health and social care professionals to ensure that people experience safe and timely discharge following a hospital stay.

The Better Care Fund (BCF) provided a mechanism to progress this integrated working and all partners have shown huge commitment and made significant progress.

The IDT consists of representatives from:

- NTHFT Discharge Liaison Service
- NTHFT Emergency Care Therapy Team
- NTHFT Acute Therapies
- LA Assessment Reablement Teams
- Social Workers from locality teams
- CHC Nurse Assessor
- Home from Hospital VCS service

As well as excellent patient / staff feedback recent results indicate that the number of delayed days has reduced by 41% between Q3 and Q4 (2016/17).

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

[Care Home Support](#)

A range of services have been established to provide support for care homes:

Pharmacy Support for Care Homes

This service was commissioned through BCF due to CQC rating a number of providers as inadequate or requiring improvement, with medication being identified as an area for concern. The aim of the service was to:

- Provide expert knowledge in the delivery of safe and effective medicines management to service users in receipt of social care / NHS funded care;
- Develop use of assessment tools based on current best practice to help identify to care homes where improvements to current practice can be made; and
- Make appropriate interventions in care homes

The service has provided advice to all 24 care homes about recommended policies and at the end of the year all 24 homes had the recommended policies in place. The service has

supported the 4 commissioned home care providers to develop medication risk assessment tools together with policy and procedures for safe handling of medicines for people supported in their own homes.

- All care homes have medicines management folders (all emailed documentation is printed and stored in this folder so all carers have access to information).
- All care homes/home care providers have contact details for medicines support.
- All care homes have access to online resources.

CQC during their regulatory inspection give judgement on the proper and safe use of medicines. Between January and December 2016, the CQC published 10 reports on inspections of Hartlepool care homes, in these inspections no concerns were reported relating to medicines.

Care Homes Education and Training Alliance

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

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

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

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

National Early Warning Score (NEWS)

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

In addition awareness sessions are being provided for Community Matrons, Rapid Response Nurses, and Clinical Triage Nurses based in the Single Point of Access who will be able to access readings for residents known to them and use NEWS as part of their

assessments. On-going sessions will be arranged to raise awareness for District Nursing teams in view of rolling out the technology and NEWS into residential homes where the community nurses have many patients.

Single Point of Access (SPA)

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

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

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

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

Dementia Friendly Hartlepool

Dementia Friendly Hartlepool aims to develop Hartlepool as a nationally recognised dementia friendly community where people living with dementia and their carers can live life well and are able to seek the help and support they need. The collaborative aims to;

- Raise awareness about dementia in key organisations and businesses within Hartlepool that support people with dementia.
- Develop a strong voice for people with dementia living in Hartlepool.
- Raise the profile of Dementia Friendly Hartlepool to increase reach and awareness to different groups in the community.
- Support local groups, businesses and charities to be dementia friendly and more accessible to those living with dementia in Hartlepool.

Key successes in 2016/17 include:

- An active DEEP group; a local branch of a national dementia empowerment and engagement network for people living with dementia.
- A multi-agency steering group working together to promote dementia awareness.
- A comprehensive programme of events in National Dementia Awareness Week and during the year to promote awareness and engage those living with dementia and carers.

- 17 businesses and companies have become dementia friendly. This includes pharmacies, florists, cafes, shops, sports facilities and more. Others are being actively sought.
- Open dementia friend's sessions offered weekly and customised sessions provided as required and tailored to the needs of a business.
- Partnership with public health has supported in-reach to primary and secondary schools to work towards a dementia friendly generation. Since September 2016, 10 Primary schools have engaged with Dementia Friendly Hartlepool.

Performance against the National BCF Metrics in 2016/17

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

Permanent Admissions to Residential and Nursing Care Homes

Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population - ASCOF measure 2A(2)		Published Data	Published Numerator	Local Data	BCF Plans		Variance from Plan	
		2014/15	2015/16	2016/17 PROVISIONAL ONLY	2015/16	2016/17	2015/16	2016/17 (latest 12 month rolling)
Hartlepool LA**	Rate	1056.3	686.6	930.2	807.8	765.7	-121.2	+164.5
	Numerator	181	119	164	140	135	-21	+29
	Denominator	17135	17331	17631	17331	17631	-	-

Q4 data indicates that there were 164 admissions in 2016/17, against a target of 135 meaning that the target for the year has not been achieved. There has been a reduction in admissions for residential care, but an increase in admissions for nursing care and data indicates that people are being admitted to residential care later and having a shorter length of stay, which reflects more people being supported to live independently in the community for longer. It should be noted that the overall number of people in receipt of residential care has fallen over the last year, although this is not reflected in this indicator, which is focused solely on admissions.

Taken over the two year period from 2014/15 to 2016/17, performance in 2016/17 represents a reduction from 181 to 164 admissions (approximately 10% reduction), and it is recognised that reported performance in 2015/16 was unusually high due to an issue with how self funders were recorded within the data.

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

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) - ASCOF measure 2B(1)		Published ASCOF 2B(1) Data		Local Data	BCF Plans		Variance from Plan	
		2014/15 (Q4 / Q3)	2015/16 (Q4 / Q3)	Q3 2016/17 (Q4 / Q3) PROVISION AL ONLY	2015/16	2016/17	2015/16	2016/17
Hartlepool LA**	%	84.9	82.9	76.2	89.2	83.1	-6.3	-6.9
	Numerator	80	68	64	58	54	+10	+10
	Denominator	95	82	84	65	65	-	-

The percentage of older people still at home 91 days after discharge into reablement / rehabilitation services is below target with year-end performance of 76.2% against a target of 83.1%, however this is an improvement compared to performance of 70% earlier in the year. This indicator will continue to be closely monitored with work being undertaken to understand the reasons why some people are not still in their homes 91 days following discharge. It should be noted that this measure of the effectiveness of reablement services only captures a small subset of the total number of people accessing reablement, with many people accessing the service from the community as a preventative measure. Local measures indicate that 583 reablement packages commenced in 2015/16 with 78.4% of people having no ongoing social care needs after a reablement intervention, and in 2016/17 94.1% of reablement goals had been achieved at the end of the period of reablement.

It is recognised that, on reflection, the target of 83.1% was very challenging and potentially unrealistic in the context of the complex needs of many people who are discharged from hospital into these services.

Non Elective Admissions: Total non-elective admissions into hospital

Hartlepool LA (based on patient Local Authority of Residence)				
Number of Non-Elective Admissions (General and Acute) - by Age Group (SUSNECS data)		2015/16 YTD	2016/17 YTD	Variance
Age Group				% Variance
0-19		1976	2249	+273
20-64		4798	5609	+811
65 & over		4825	5201	+376
Total (all ages)		11599	13059	+1460

The Q3 and Q4 returns confirmed that all national conditions continue to be achieved, there are a range of developments which could have contributed to this and not any single one of them can be directly attributed, it is as a result of a collaboration of developments. The analysis of performance data is summarised below:

There was an overall increase of 12.6% in NEL admissions in 2016/17 compared to the previous year, with 26.8% growth in ambulatory care admissions. BCF is performance managed based on all NEL admissions regardless of age, although the BCF plan and initiatives are focused on over 65s. Analysis based on age indicates that NEL admissions increased for over 65s by 7.8%. Growth in other age groups was significantly higher at 14.2% for 0-19yrs and 16.8% for people aged 20-64yrs.

Delayed Transfers of Care: Delayed transfers of care (DToC) from hospital per 100,000 population (days delayed)

Delayed transfers of care from hospital per 100,000 population (18+)	2016/17			
	Q1 2016/17 (Apr16-Jun16)	Q2 2016/17 (Jul16-Sep16)	Q3 2016/17 (Oct16-Dec16)	Q4 2016/17 (Jan17-Mar17)
Quarterly Rate (Actual)	1174.9	1892.5	2848.4	1553.3
Quarterly Rate (Plan)	342.4	342.4	342.4	341.2
Numerator (Actual)	858	1382	2080	1138
Numerator (Plan)	250	250	250	250
Denominator	73024	73024	73024	73265

During Q4 there were 1,138 days delay reported meaning that the target has not been achieved. The main reasons for reported delays were 'awaiting nursing home placement' (30%); 'patient or family choice' (21%) and 'awaiting completion of assessment' (20%). A key challenge over the past 12 months has been availability of nursing home beds, which accounts for 44% of delays for the year. This position is expected to improve in 2017/18 with new nursing home provision available from May 2017 and potential further developments later in the year.

Dementia diagnosis: Estimated diagnosis rate for people with dementia

Estimated diagnosis rate for people with dementia	Snapshot			BCF Plans	
	Mar 15	Mar 16	Mar 17	2015/16	2016/17
Percentage	79.07 %	76.47 %	75.13 %	69.01%	76.13%
Numerator = QOF Dementia register (all ages) based on GP Practice locality to determine HWB	899	913	897	824	909
Denominator = Denominator figure submitted in the BCF Plans template for appropriate financial year and HWB	1137	1194	1194	1194	1194

Performance is 1% below target at the year end, which represents 12 less people being diagnosed than was aimed for.

Local performance report

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

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

Please see appendix 1 – Copy of BCF Performance Report quarter 4 2017.

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

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

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

Plan of Action

Issue	Challenge	Action
Over performance against emergency admissions (65 and over) metric.	To contribute to reducing avoidable hospital admission for over 65 population.	<p>Further trend analysis to better understand impact of BCF funded schemes and CCG commissioned services to inform future commissioning plans.</p> <p>Contribute to the CCG Quality Innovation Productivity Prevention programme to deliver the proposed CCG Non-elective trajectory.</p> <p>Scope early intervention and intermediate care services across health and social care to determine new model of care to support a reduction non-elective activity.</p>
Over performance for length of stay for emergency admissions (65 and over).	To contribute to reducing length of stay relating to emergency admission for over 65s.	<p>Further trend analysis to identify areas of variation and over performance across clinical pathways in relation to excess bed days.</p> <p>Build on the discharge to assess model to support discharges, as set out above.</p> <p>Work closely with the Acute Trust to ensure delivery of the supportive, proactive and safe discharge 2 year CQUIN scheme.</p>
Low number of people being discharged on a weekend, following an	To increase the number of patients discharged on a weekend following an	Work in partnership across health and social care to determine services (in and out of hospital) required to

emergency admission (over 65s)	emergency admission (over 65s)	support and improve weekend discharges. Build on the discharge to assess model to support discharges set out above to address the delayed transfers of care.
Over performing on total delayed days per 100,000	To contribute to reducing hospital delayed discharge days.	Jointly commission a fully integrated discharge team across health and social care. Improve patient discharge pathways promoting a 'home first' concept. Agree one joint assessment and care plan as part of the discharge process. Roll out the trusted assessor role across discharge pathways Reduce the number of CHC assessments undertaken in the acute setting. Improve the weekend discharge pathway.
Under performing on the proportion of people 65 and over who are still at home 91 days after discharge from hospital into reablement /rehabilitation services	To improve the number of people who are at home 91 days post discharge from hospital into reablement/ rehabilitation	Further analysis of reasons why people are not still at home after 91 days. Better targeting of reablement resources. Development of integrated approach to intermediate care, which will include reablement.
Growth of over 65 population with long term conditions and the impact on health and social care services by 2020.	Reduce impact of long term conditions and promote self management and self care.	Increased focus on equipping people to be resilient and self-reliant through: <ul style="list-style-type: none"> • Social prescribing and supporting the VCSE • Continued promotion and development of Hartlepool Now

		<ul style="list-style-type: none"> • Digital care solutions • Further integration of services to reduce duplication and ensure that resources are used effectively across health and social care to manage increasing demand.
Adult Health and Social Care Market	Support the development and sustainability of a vibrant market for health and social care.	<p>Use of iBCF to support sustainability of the care market.</p> <p>Care Quality Improvement Programme.</p> <p>Maintain positive working relationships with the market to understand and anticipate pressures and influence market shaping.</p>
Reducing resource across the health and social care services	Maintaining and improving current services and performance in the context of reducing resources and increasing demand.	<p>Improve information, advice and signposting that support people to maintain their health, wellbeing and independence without input from statutory services.</p> <p>Further integration of services to reduce duplication and ensure that resources are used effectively across health and social care to manage increasing demand.</p> <p>Use of the iBCF to protect adult social care.</p> <p>Use of iBCF to reduce pressures on the NHS through new models of care.</p>

6. Better Care Fund Plan 2017-2019

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

The agreed priorities for 2017-2019 are:

- New Models of Care
- Integrated Hospital Discharge
- Integrated Intermediate Care
- Integrated SPA
- Care Quality Improvement Programme

New Models of Care

Primary Care Care co-ordination

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

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

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

Community Hubs

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

In Hartlepool this is being piloted at local community level through a group of GP practices working with key health and social care partners as a 'Community Integrated Services Pilot'. The primary purpose of the Community Integrated Services pilot at McKenzie House is to provide more timely access to assessment, treatment and support for the frail elderly by facilitating closer communication and collaboration between health and social care practitioners working in the community. It is anticipated that by sharing relevant information, improving coordination and more proactively engaging with identified people, community based health and social care resources will be maximised and people will receive a more targeted and responsive service.

It is anticipated that this collaboration will lead to: -

- Reduced avoidable hospital admissions
- Reduced average length of stay in hospital
- Reduced admissions into residential / nursing care
- People will feel safer and more confident
- There will be an improvement in people's quality of life and the service delivery across health and social care will be more person centred
- Carers will feel more supported to continue in their caring role.

Feedback from patients and practitioners is positive but demonstrating the impact of the pilot has been challenging as there is not one system that collates this information. In 2017/18 further consideration will be given to how the success of the model can be evidenced and how the approach can be rolled out within the capacity constraints across the health and social care organisations involved.

Integrated Hospital Discharge

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

Further work is needed to develop and embed trusted assessor models, as approaches are currently being developed and piloted but are not well established across the health and social care system. In Hartlepool the trusted assessor approach has been piloted initially within the elective orthopaedic pathway. This has worked well and options to extend and roll out to other pathways are being considered. The Integrated Discharge Team will also be exploring further ways to improve systems, reduce duplication and intervene more proactively at the earliest possible stage to facilitate safe and timely discharge.

These initiatives, along with increased availability of nursing beds (which has been a significant challenge for the last 18-24 months) are impacting on DToCs with significant reductions in Q4 of 2016/17 and a shared expectation that the integrated work that's underway will result in further reductions during 2017/18.

Integrated Intermediate Care

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

- enhanced social care and / or health support in a person's normal place of residence to prevent an admission; and
- development of 24hr nurse led step up provision;

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

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

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

Integrated SPA (iSPA)

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

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

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

The following criteria will demonstrate success of the iSPA:

- Effective pathways for people requiring health and/or social care needs
- Improved rates of response to referrals with timely decision making, less delay associated with information gathering and reduced duplication;
- Reduction in number of re-referrals;
- Reduction in the number of hospital admissions for people known to Out of Hospital services

- Reduction in the number of people requiring admission to care homes
- More holistic triage of people's needs;
- Increased referrals to non-statutory services for simple needs

Care Quality Improvement Programme

The Care Quality Improvement Programme (CQIP) brings together all of the current initiatives that are underway to support care home and care home providers, along with additional financial support through iBCF funding to demonstrate the commitment across health and social care to drive improvements in care quality. This is supported through a multi agency Care Home Commissioning Group and further developments will be informed by analysis of data regarding hospital activity linked to care home settings, enabling resources to be effectively targeted where there is likely to be greatest impact.

7. Use of iBCF

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

Support for the Local Care Market

Recent experiences with care home provision have evidenced that ensuring there is an adequate supply of care home placements is essential to prevent delayed transfers of care, and the same applies to ensuring that people can access home care packages in the community. The care home and home care sectors are facing significant financial challenges with concerns being highlighted nationally, regionally and locally about the fragility of the market and the potential for providers to cease trading.

Care home and home care rates will be increased in recognition of the pressures being faced by care home providers and the potential for providers to leave the market as a result. The outcome will be a more sustainable care market in relation to care home placements and home care packages for older people.

Protection of Adult Social Care

Without additional funding to offset further cuts to Council funding, there will be a significant reduction in core adult social care services over the coming three years which will impact on direct delivery of services, including caseloads, waiting times, user satisfaction and complaints. A reduction in core services would also potentially impact on delayed transfers of care and admissions to care homes as there would be less staffing resource available to work effectively in integrated teams and to support people to develop packages of care in the community that are focused on maintaining independence and admission avoidance.

There are already pressures of £1m in adult services that need to be managed over the next two years through demand management initiatives. If savings to manage these pressures cannot be identified from spend on placements and community packages, the only other alternative is to make cuts in other budget areas which will inevitably include frontline staffing. This needs to be considered in the context of funding cuts over the past five years and further planned cuts across the Council over the next three years.

Reducing Pressures on the NHS through New Models of Care

A significant amount of work has been done, over the last 12 months in particular, to reduce pressures on the NHS through improving hospital discharge processes. This includes weekend and bank holiday working, establishment of the Integrated Discharge Team and the development of Integrated Discharge Pathways, implementation of the Home from Hospital Service and the discharge to assess / trusted assessor pilot for the elective orthopaedic pathway. Relationships are very positive and staff are working well together to improve outcomes for people, and recent data indicates that the number of delayed days reduced by 41% between Q3 and Q4 (2016/17). Supporting adult social care and sustaining the local care market will enable the current work to reduce DToCs to be maintained and will also support further work to roll out the discharge to assess / trusted assessor model. An element of the iBCF funding is required to maintain the social care function within the Integrated Discharge Team, which was initially funded as a short term pilot.

Increased capacity is needed to deliver intermediate care / reablement, both in a proactive preventative way and a reactive way following hospital discharge. There is also potential for services to be delivered in a more integrated way as outlined above.

An increased focus on reducing avoidable non elective admissions to hospital is also required through investment in step up services and further development of new models of working with primary care.

It is recognised that attracting people to health and social care entry level jobs can be challenging, and also that career progression is limited in some areas of work. There are also areas of the workforce that are ageing where succession planning is needed. In order to address this, options to support workforce planning through creating a Care Academy are being explored. Initially this will involve creating traineeships within intermediate care services with opportunities for placements across health and social care.

Although there has been significant investment in assistive technology, and uptake continues to increase, it is recognised that technological advances have been made in recent years that present further opportunities in this area. It is proposed that new assistive technology options are explored and tested with the aim of better managing demand and promoting independence.

It is proposed that the resource available to support new models of care is utilised over the three years 2017/18, 2018/19 and 2019/20 in the expectation that new models of care can become embedded by 2020 and will deliver efficiencies within the health and social care system that enable them to be maintained on a recurrent basis.

It is anticipated that a reduction in DToCs can be achieved through investment in the Integrated Discharge Team, intermediate care provision and Trusted Assessor models with a reduction in avoidable NEL through investment in step up services and new models of working with primary care.

8. Use of DFG Funding

Additional investment in DFGs over the past two years has enabled the waiting list to be addressed and waiting times to be reduced by almost 50%. The continued growth in DFG funding will enable this position to be maintained and further improved over the next two years.

The table below summarises adaptations completed in 2016/17 using DFGs:

DFGs Completed 2016/17					
Type of Adaptation	Under 18	18-40 yrs	40-65 yrs	65-80 yrs	80+ yrs
Straight Stairlift	0	1	9	14	17
Curved Stairlift	0	1	2	8	13
Extension	4	0	2	1	0
Level Access Shower	0	3	40	51	41
Over Bath Shower	2	2	7	1	1
Ramp	3	0	1	2	1
Other	2	2	2	2	0
Total	11	9	63	79	73

9. Risk

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

There is a risk that:	Likelihood	Potential impact	Overall risk factor	Mitigating Actions
There is insufficient information and data at the correct level and quality to effectively monitor outcomes and ensure overall delivery of the BCF plan.	1	3	3	<ul style="list-style-type: none"> Health and social care information team's work together to ensure that information is collected and presented meaningfully to inform planning and service development. BCF work streams provide assurance that existing and planned developments deliver required outcomes. Reviews are undertaken to refine plans and there is potential to disinvest in schemes that fail to deliver outcomes National performance measures are used where appropriate and where these are not available, locally agreed indicators are developed.
The schemes are not in line with existing NHS or LA delivery plans undoing existing good practice.	1	4	4	<ul style="list-style-type: none"> Partners continue to be involved in development of BCF plans to ensure that organisational plans are aligned. The agreed governance arrangements ensure that the impact of decisions relating to BCF implementation are considered by all partners on the North of Tees Partnership Board. Plans build on the good practice already in place prior to BCF.

There is insufficient time for schemes to have the impact in the short term on performance and savings.	2	4	8	<ul style="list-style-type: none"> Plans build on existing good practice. Existing services will contribute to delivery of the BCF plan. Contractual mechanisms are used where appropriate to ensure that changes are delivered within agreed timescales.
As current funding to social care is reduced there will be a detrimental impact on the delivery of savings and BCF outcomes.	4	5	20	<ul style="list-style-type: none"> BCF funding to maintain social care provision has been agreed for 2017/18. The North of Tees Partnership Board will continue to monitor the impact of changes to social care funding and risks posed to the BCF. iBCF will enable further protection of social care services, along with support for the care market.
Workforce skill mix and availability to deliver the new pathways of care is not adequate.	3	4	12	<ul style="list-style-type: none"> Workforce planning and development with Health Education North East and NHS England Local Area Team continues. Difficulty recruiting nurses across the health and social care system remains a challenge.
Shifting resources to fund new integrated services destabilises current providers, particularly in the acute sector.	2	4	8	<ul style="list-style-type: none"> This has been managed successfully to date and will continue to be reviewed regularly.

2017/18 BCF Local Risk Share/contingency arrangements

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

National Conditions

National Condition 1: Jointly Agreed Plan

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

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

This joint planning enables partners to develop services that will contribute to reducing pressures on urgent care and prevent people needing emergency care in hospital or a permanent care home admission. It is expected that this will continue in 2017/18 and beyond as part of wider transformation plans (STP).

Joint planning has been supported by a range of events focused on specific developments within the BCF plan, engagement events with older people and carers and the work of the North of Tees Dementia Collaborative.

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

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

National Condition 2: Social Care Maintenance

The agreed local definition of maintaining provision of social care services is 'ensuring that people in Hartlepool with eligible social care need continue to be supported in a time of increasing demand due to the ageing population, and reducing local government resources'.

This will be achieved through further integration of services that proactively intervene to support people at the earliest opportunity, ensuring that they remain well, are engaged in the management of their own wellbeing and, wherever possible, are able to stay in their own

homes and retain their independence while contributing to their local communities for as long as they are able to.

As outlined in the planning template, the allocation from the BCF to support maintenance of adult social care services in 2016/17 was £3.198m. This level of funding was determined based on the original NHS Transfer to Social Care in 2013/14 of £2.3m which continued to maintain existing integrated services supporting timely hospital discharge and delivery of reablement and telecare services, commissioning of low level services, support for ongoing care packages in the community and support for carers. Additional resources were identified in 2015/16 to protect adult social care services which would otherwise be at risk including low level services to support people with long term conditions and sensory loss; and assistive technology services that support people to remain independent in their own homes. This level of funding will be maintained in 2017/18 with inflationary uplifts applied.

National Condition 3: NHS Commissioned Out-of-Hospital Services

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

The Financial Summary in the planning template shows that there is an investment in NHS Commissioned out of hospital services of £2,015,644 This is broken down by:

Out of Hospital Investment	Hartlepool
Community Health	724,000
Mental Health	262,500
Social Care	814,144
Other	213,000
Total	2,015,644
Minimum contribution required	1,937,849

The local area's share of the £1 billion previously use for the payment for performance set out in the BCF Allocations is £2,015,644. This shows that there has been a greater investment in NHS Commissioned out of hospital services of £77,795 more than the minimum required.

National Condition 4: Managing Transfers of Care

A self assessment of local progress against the High Impact Change Model has been undertaken and an update was provided to the Local A&E Delivery Board in June 2017. The self assessment identified that significant progress has been made in relation to early discharge planning, monitoring of patient flow, multi agency discharge teams, discharge to assess, seven day services, focus on choice and enhancing health in care homes. Some of the positive initiatives that were highlighted, which had been commissioned through the BCF Pooled Budget, were the Home from Hospital Service that provides very short term low level support to older people on discharge from hospital who have not been assessed as having ongoing social care needs; pharmacy support for care homes, which has had a positive

impact in terms of reducing safeguarding alerts and improving outcomes for care home residents; and a training and education programme for care homes, incorporating use of NEWS, which promotes early identification and intervention when a resident is experiencing a decline in their health. In addition the CCG has reconfigured the Community Matron model (not BCF Funded) to support the care home sector and in particular those patients being discharged back to care homes under an agreed pathway until further assessment can be undertaken as an appropriate assessment.

It has been identified that further work is needed to develop and embed trusted assessor models, as approaches are currently being developed and piloted but are not well established across the health and social care system. In Hartlepool the trusted assessor approach has been piloted initially within the elective orthopaedic pathway. This has worked well and options to extend and roll out to other pathways are being considered. These initiatives, along with increased availability of nursing beds (which has been a significant challenge for the last 18-24 months) are impacting on DToCs with significant reductions in Q4 of 2016/17 and a shared expectation that the integrated work that's underway will result in further reductions during 2017/18. In June 2017 the A&E Delivery Board received a presentation regarding the self-assessment against the [High Impact Change Model](#).

10. Overview of Funding Contributions

Funding	2017/18	2018/19
CCG Minimum Contribution	£6,819,287	£6,948,857
Disabled Facilities Grant	£930,517	£997,971
IBCF Allocation	£2,707,874	£3,737,159
TOTAL	£10,457,769	£11,683,987

Care Act 2014 Monies

£288k was identified from the BCF pooled budget in 2016/17 to support implementation of the Care Act duties. This funding will be maintained in 2017/18 and will continue to support staffing costs associated with undertaking additional social work and related assessments, costs associated with the statutory Safeguarding Adult Board and new duties relating to information, advice and advocacy.

Reablement Funding

Former 'Reablement Funding' continues to support a range of services including; a Community Dementia Liaison Service and input from Community Nursing Services to rehabilitation beds provided in a care home in the community. This funding continues to support safe and timely hospital discharges with services focused on maximising independence and reducing the risk of readmission to hospital.

Carers' Break Funding

Funding identified for carers will continue to meet the needs of informal carers through a range of services including; direct payments that allow carers to access short breaks in a way that is flexible to meet their individual needs; a carers support organisation that provides advice, information, peer support and support to access training and employment and respite services that provide carers with a break from their caring role. Feedback from the latest national Carers Survey indicates that most carers in Hartlepool are very satisfied with the support they receive.

Social Care

As outlined in relation to National Conditions, the allocation from the BCF to support maintenance of adult social care services in 2016/17 was £3.198m. This level of support is maintained in the 2017 – 2019 BCF plan.

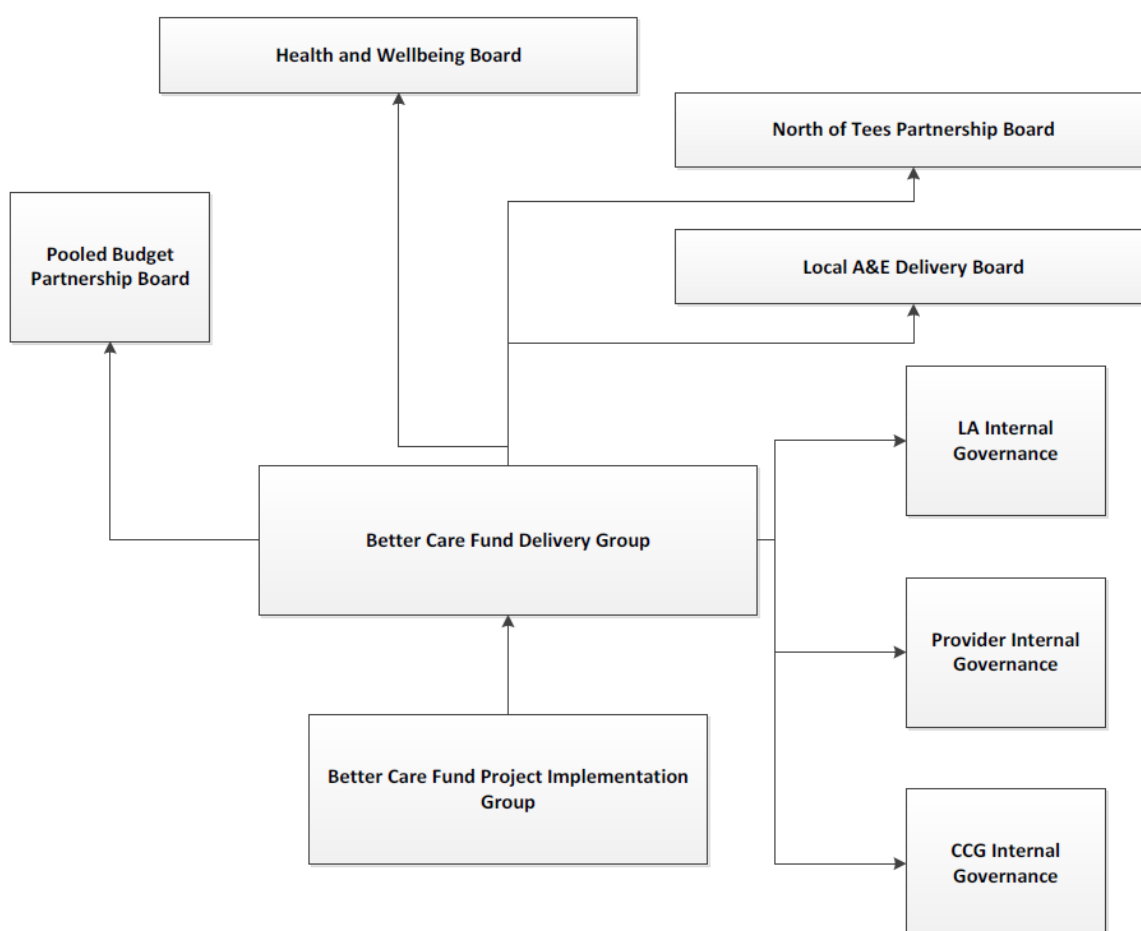
iBCF

As outlined earlier in the document, the iBCF will be used to support the sustainability of the local care market, protect adult social care services that would otherwise be subject to significant cuts and reduce pressures on the NHS through new models of care.

11. Programme Governance

Robust governance arrangements for the Hartlepool Better Care Fund Plan were agreed by the Health and Wellbeing Board in April 2014. These governance arrangements reflect the partnership approach that is required to effectively deliver the integrated approach described in the Better Care Fund Plan but also acknowledge the needs of individual partner organisations to ensure that decisions are taken through their own internal governance arrangements. The agreed governance arrangements ensure that a system wide perspective and approach is taken through the North of Tees Partnership Board which covers the Hartlepool & Stockton-on-Tees CCG Unit of Planning.

The diagram below sets out the new governance arrangements for the Hartlepool Better Care Fund (BCF) programme for 2017/19.



The Hartlepool Health & Wellbeing Board is responsible for; signing off and ensuring delivery on the Hartlepool Better Care Fund Plan; ensuring that the BCF plan responds to local needs, is aligned with the Health & Wellbeing Strategy and supports system integration across health and social care; agreeing the use of funding under the Better Care Fund pooled budget arrangements; addressing any risks and issues arising that relate to the wider Hartlepool health and social care system; and progressing any joint commissioning implications and requirements arising from the Better Care Fund.

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

The North of Tees Partnership Board brings together key partners across the Unit of Planning to provide strategic leadership and oversight to the development and delivery of the Hartlepool and Stockton-on-Tees Better Care Fund Plans. Ensuring alignment with wider strategic plans across health and social care; co-ordinating and aligning all cross-organisational activities across the health and social care economy aimed at delivering service change; addressing risks and issues that might impact on the delivery of the Better Care Fund; agreeing contingency and risk management arrangements in the event that planned schemes do not deliver to projections; coordinating and sharing how decisions will be taken within partner organisations; and supporting assurance processes.

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

The BCF Delivery Group is responsible for; ensuring delivery on the Hartlepool BCF plans; developing new pathways and models of care; ensuring that partner organisations have taken decisions through their internal governance processes in order for decisions to be made and holding the BCF Implementation Group accountable for; ensuring each organisation provides sufficient resources to the work streams to ensure successful implementation of the programme; developing a joint communications strategy; resolving and appropriately escalating issues and risks associated with the Better Care Fund, including performance and finance; ensuring other groups are updated and assured of progress.

The BCF Project Implementation Group is responsible for developing the pathways and models of care under each of the BCF schemes; resolving issues and risks which are within the remit of the project; developing the detailed implementation plans and taking day-to-day responsibility for implementation once the new pathways and models of care have been agreed.

Each of the partner organisations ensures that decisions are taken through their own internal governance structures and information is shared. For example the CCG Exec and Governing Body will be kept apprised of developments and informed of the progress of all plans; this is intended to be through development sessions and/or Governing Body meetings. Member practices of the CCG will also be kept apprised through clinical time out events, Clinical Reference Groups and Council of Member meetings.

12. National Metrics

Non-elective Admissions

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

FOT 16/17	40274	2017/18				2018/19			
FOT 17/18	39,815	Annual activity % change		-1.10%		Annual activity % change		0.7%	
FOT 18/19	40,106	Annual activity actual		-459		Annual activity actual		291	
		Apr-17	3,114	Q1	9,323	Apr-18	3140	Q1	9,402
		May-17	3,040			May-18	3067		
		Jun-17	3,169			Jun-18	3195		
		Jul-17	3,207			Jul-18	3232		
		Aug-17	3,114	Q2	9,526	Aug-18	3140	Q2	9,602
		Sep-17	3,205			Sep-18	3230		
		Oct-17	3,344			Oct-18	3368		
		Nov-17	3,365			Nov-18	3388		
		Dec-17	3,349	Q3	10,058	Dec-18	3372	Q3	10,128
		Jan-18	3,563			Jan-19	3585		
		Feb-18	3,541			Feb-19	3564		
		Mar-18	3,804			Mar-19	3825		

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

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

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

Admissions to Residential Care Homes

The target set for 2017/18 is 148 admissions and to maintain at 2018/19. This is a challenging target (representing a further 10% reduction) which has been set based on performance over the last 12 calendar months including performance in Q1 of 2017/18.

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

Effectiveness of Reablement

The target set for 2017/18 is 80% and to maintain at 2018/19, which represents a 5% increase on actual performance in 2016/17 of 76.2%. It is anticipated that this can be achieved through better understanding the reasons why people are not still at home 91 days after discharge and then targeting resources more effectively. Work to ensure that resources are being used effectively has already commenced and as a result, the proportion of people accessing reablement for more than 7 weeks has reduced from 45% to 30% over the last 12 months.

Delayed Transfers of Care

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

The trajectory set for Hartlepool requires the total number of delayed days to reduce to 206 by November 2017. This is a 46% reduction from the Q4 position. In Hartlepool this means a significant reduction in the delays attributable to the NHS but, with the opening of new Care Homes and through continued partnership working, is felt to be deliverable.

Supportive Proactive and Safe Discharge CQUIN

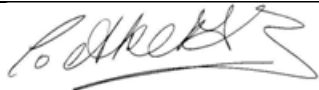
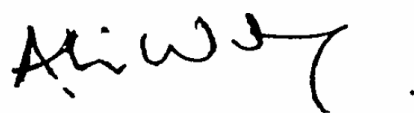
The CCG is also working closely with the Trust on the new Supportive Proactive and Safe Discharge CQUIN should also support the proposed reductions, this two year CQUIN aims to improve patient outcomes, improve patient flow and reduce delayed discharges. In year one (2017/18) acute providers are required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

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

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

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

13. Approval and Sign Off

APPROVAL – Final Submission: 11 September 2017	
Name	Cllr Christopher Akers Belcher (Chair) Hartlepool Health and Wellbeing Board
Signature	
Date	11/09/17
Name	Ali Wilson, Chief Officer Hartlepool and Stockton-on-Tees CCG
Signature	
Date	15/09/2017

14. Key Lines of Enquiry

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

	BCF Planning Requirements	KLOEs to support assurance of the planning requirements	Where
National condition 1: jointly agreed plan (Policy Framework)	<p>1. Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and wellbeing board?</p> <p>2. In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?</p>	<p>1. Are all parties (Local Authority and CCGs) and the HWB signed up to the plan?</p> <p>2. Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan?</p> <p>3. Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach?</p>	<p>Narrative plan pages 3 & 43</p> <p>Narrative plan pages 3 & 43,44</p> <p>N/A as Unitary Authority</p> <p>Planning Template</p>
National condition 2: Social Care Maintenance (Policy Framework)	<p>3. Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19</p> <p><i>*1.79% for 2017/18 and a further 1.90% for 2018/19</i></p>	<p>4. Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template?</p> <p>5. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution?</p> <p>6. In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole?</p> <p>7. Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision</p>	<p>Narrative plan page 42</p> <p>Narrative plan page 39</p> <p>Narrative plan page 32, 33, 39 & 42</p> <p>Narrative plan 39, 40 & 42</p> <p>Planning Template</p>

National condition 3: NHS commissioned Out of Hospital Services (Policy Framework)	4. Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?	8. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? 9. If an additional target has been set for Non Elective Admissions; have the partners set out clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid? 10. If a contingency fund is established; is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?	Planning Template Narrative Plan Pages 40 & 41 N/A Narrative plan page 39
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	5. Is there a plan for implementing the high impact change model for managing transfers of care?	11. Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken; including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? 12. Is there evidence that a joint plan for delivering and funding these actions has been agreed? 13. If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information?	Planning Template Narrative plan pages 40 & 41 Narrative plan page 39 - 40 Narrative plan page 34-35, 39-40 and Appendix 1

Local vision for health and social care	6. A clear articulation of the local vision for integration of health and social care services?	<p>14. Does the narrative plan articulate the local vision for integrating health and social care services, including changes to patient and service user experience and outcomes, and a strategic approach to housing, social care and health, cross-referenced and aligned to other plans impacting on integration of health and social care such as STPs or devolution deals?</p> <p>15. Is there an articulation of the contribution to the commitment to integrate health and social care services by 2020 in line with the intent set out in the 2015 spending review and the BCF policy Framework?</p> <p>16. Is there a description of how progress will continue to be made against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework?</p>	<p>Narrative plan pages 4 through 9 outlines KLOE 14 and 15 in detail</p> <p>Narrative plan page 8-9</p>
Plan of action to contribute to delivering the vision for social and health integration	7. Does the BCF plan provide an evidence-based plan of action that delivers against the local needs identified and the vision for integrating health and social care?	<p>17. Is there a robust action plan that addresses the challenges of delivering the vision, including:</p> <ul style="list-style-type: none"> • Quantified understanding of the current issues that the BCF plan aims to resolve • Evidence based assessment of the proposed impact on the local vision for integrating health and social care services through the planned schemes and joint working arrangements 	Narrative plan pages 10-16, 23-26, 27-29 and Appendix 1

Approach to programme delivery and control	8. Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when needed?	<p>18. A description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF plan?</p> <p>19. A description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010?</p> <p>20. Does the narrative plan have a clear approach for the management and control of the schemes? including as a minimum:</p> <ul style="list-style-type: none"> • Benefit realisation (how will outcomes be measured and attributed?) • Capturing and sharing learning regionally and nationally • An approach to identifying and addressing underperforming schemes 	<p>Narrative plan page 43-44</p> <p>Narrative plan page 10</p> <p>Narrative plan pages 5, 43 & 44 and Appendix 1</p>
Management of risk (financial and delivery)	9. Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?	<p>21. Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description of how these risks will be proportionally mitigated or managed operationally?</p> <p>22. If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care or IBCF grant at risk?</p> <p>23. Is there sufficient mitigation of any financial risks created by the plan if a risk share has not been included?</p>	<p>Narrative plan pages page 37-39 Market Position Statement – narrative plan page 8 Narrative plan page 37-39</p> <p>Narrative plan page 37-39</p>

Funding contributions: Care Act, Carers' breaks, Reablement DFG iBCF	10. Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose and this is appropriately agreed with the relevant stakeholders and in line with the National Conditions?	<p>24. For each of the funding contributions, does the BCF evidence:</p> <ul style="list-style-type: none"> • That the minimum contributions set out in the requirements have been included? • How the funding will be used for the purposes as set out in the guidance? • That all relevant stakeholders support the allocation of funding? • The funding contributions are the mandated local contributions for: <ul style="list-style-type: none"> • Implementation of Care Act duties • Funding dedicated to carer-specific support • Funding for Reablement • Disabled Facilities Grant? <p>25. Does the planning template confirm how the minimum contribution to Adult Social Care and the funding for NHS Commissioned Out of Hospital Services will be spent?</p> <p>26. Does the BCF plan set out what proportion of each funding stream is made available to social care and that the improved Better Care Fund has not been offset against the contribution from the CCG minimum?</p> <p>27. Is there agreement on plans for use of IBCF money that meets some or all of the purposes set out in the grant determination?</p>	<p>Narrative plan page 40 and 42 Planning Template</p> <p>Narrative plan page 47 Planning Template</p> <p>Planning Template</p> <p>Narrative plan page 40-42 Planning Template</p> <p>Narrative plan page 34-35</p>
Metrics – Non Elective Admissions	11. Has a metric been set for reducing Non Elective Admissions?	<p>28. Does the narrative plan include an explanation for how this metric has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?</p> <p>29. Has a further reduction in Non Elective Admissions, additional to those in the CCG operating plan, been considered?</p>	<p>Planning Template Narrative plan page 45</p> <p>N/A</p>
Metrics – Non Elective Admissions (additional)	12. If a metric has been set for a further reduction in Non Elective Admissions, beyond the CCG operating plan target, has a financial contingency been considered?	<p>30. Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target? See also National Condition 3.</p>	<p>Narrative plan page 45 Planning Template</p>

Metrics Admissions to residential care homes	13. Has a metric been set to reduce permanent admissions to residential care?	31. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?	Planning Template Narrative plan page 45
Metrics – Effectiveness of Reablement	14. Has a metric been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?	32. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of the reablement funding allocation for health and social care and other BCF schemes on performance in 2017-19?	Planning Template Narrative plan page 46
Metrics Delayed Transfers of Care	15. Have the metrics been set for Delayed Transfers of Care?	33. Have all partners agreed a metric for planned reductions in delayed transfers of care across the HWB that is at least as ambitious as the overall HWB target for reductions of DToC by November 2017? 34. Is the metric in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area set out in the DTOC template? 35. If the local area has agreed changes in attribution from those set out in the template is there a clear evidence base and rationale for those changes? 36. Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan? 37. Have NHS and social care providers been involved in developing this narrative?	Planning Template Narrative plan page 46 across KLOE 33, 34, 35, 36 and 37 Related schemes and models impacting DTOC beyond BCF A&E improvement plans
Integrity and completeness of BCF planning documents	16. Has all the information requested in the DTOC and planning templates been provided and are all the minimum sections required in the narrative plan elaborated?	38. Have the DTOC template, Planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? (Better Care Support Team will carry out central data validation)	DTOC template Planning Template Narrative plan page 46



Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

Better Care Fund

HARTLEPOOL

Pooled Budget Partnership Performance Report (Quarter 4: Jan - March 2017)

Date **July 2017**

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TABLE OF CONTENTS

Contents

1.0 INTRODUCTION	56
2.0 NATIONAL PERFORMANCE METRICS SUMMARY	56
2.1 National Performance Metrics	56
2.2 Overall Summary – Q4 Position (January - March 2017)	57
2.3 Admissions to residential and nursing care homes	57
2.4 Reablement/ Rehabilitation Services	58
2.5 Delayed Transfers of Care (DToCs)	60
2.6 Non-Elective Admissions	61
2.7 Estimated diagnosis rate for people with dementia	62
3.0 LOCAL PERFORMANCE FRAMEWORK	63
APPENDIX 1: CARE HOME ACTIVITY	77
APPENDIX 2: REABLEMENT ANALYSIS	83
APPENDIX 3: DELAYED TRANSFERS OF CARE ANALYSIS	86
APPENDIX 4: DELAYED TRANSFERS OF CARE UPDATE	89
APPENDIX 5: NON ELECTIVE Analysis	90
APPENDIX 6: CARE HOME TRAINING PROGRAMME	99
APPENDIX 7: McKENZIE HOUSE PILOT	114
APPENDIX 8: SPA CLINICAL TRIAGE PERFORMANCE	116
APPENDIX 9: PHARMACY SUPPORT INTO CARE HOMES Performance Report	123
APPENDIX 10: HOME FROM HOSPITAL	135
APPENDIX 11: INTEGRATED DIGITAL CARE RECORDS UPDATE	138

1.0 INTRODUCTION

The purpose of this report is to provide the Hartlepool Pooled Budget Partnership Board with an update with regards to the following:

- The six national performance metrics which are used to determine the success of the Better Care Fund
- The position in relation to the local set of performance measures established to complement the national measures
- Specific outcomes linked to the BCF schemes
- Actions/ next steps

2.0 NATIONAL PERFORMANCE METRICS SUMMARY

2.1 National Performance Metrics

The six national performance metrics which are used to determine the success of the Better Care fund are:

1. **Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population**
2. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (effectiveness of the service)**
3. **Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)**
4. **Non-Elective Admission (General and Acute)**
5. **Estimated diagnosis rate for people with dementia**
6. **Service user experience**

The current position for Hartlepool, including key issues and actions are summarised below.

2.2 Overall Summary – Q4 Position (January - March 2017)

Indicator	Level	Period	Actual	Plan	Variance	Percentage
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate per 100,000 pop.	2016/17 PROVISIONAL ONLY	930.2	765.7	+164	21.48%
	Numerator		164	135	+29	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (effectiveness of the service)	%	Q3 2016/17 (Q4 / Q3) PROVISIONAL ONLY	76.2	83.1	-6.9	-8.31%
	Numerator		59	54	+5	9.26%
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Rate per 100,000 pop.	Q4 2016/17 (Jan17-Mar17)	1553.3	341.2	+1,212	355.20%
	Numerator		1138	250	+888	
Non-Elective Admissions (General and Acute)	Numerator	Q4 2016/17 (Jan17-Mar17)	3261	2819	+442	15.68%
Estimated diagnosis rate for people with dementia	%	Mar17	75.13%	76.13%	-1.01%	
	Dementia Register		897	909	-12	
Aggregate of 3 Measures: Measure 1. ASCOF 3A Measure 2. ASCOF 3B	Aggregated %	ASCOF 3A: 2015/16 (Hartlepool) / 2014/15 (Stockton);	74.4%	74.4%	+0.02%	
	Aggregated Numerator		2697.7	2473.0	+225	

2.3 Admissions to residential and nursing care homes

Current position: Not achieving against the 2016/17 BCF plans.

Key Issues: Q4 data indicates that there have been 164 admissions in 2016/17, against a target of 135 meaning that the target for the year has not been achieved. There has been a reduction in admissions for residential care, but an increase in admissions for nursing care and data indicates that people are being admitted to residential care later and having a shorter length of stay, which reflects more people being supported to live independently in the community for longer. The overall number of people in over 65 places is the same as a year ago, with a peak of 581 people in Oct 2016. There has been an increase in nursing placements from 114 to 129 (increase of 13%), while residential placements have decreased from 447 to 432 over the same period (3% drop), although this is susceptible to changes on a monthly basis. Data over the last 3-4 years shows peaks and troughs for both residential and nursing, however compared to 4 years ago nursing placements are 5% down (136 to 129) while residential placements have also reduced by only 1% (436 to 432). (Taken from Appendix 1)

This is a measure that is very closely monitored by the Council on a monthly basis, and any changes to trends are highlighted and examined.

Key Actions:

- Continue to promote services that offer alternatives to 24hr care, which include assistive technology, housing related support, extra care, domiciliary care, personal budgets and support for carers.
- Continue to monitor occupancy levels, average age at admission and average length of stay which provide further information about the use of 24hr care. Current data indicates that people are being admitted to residential care later and staying for shorter periods of time, indicating that people are being supported in the community for longer and have more complex needs on admission.
- Continue to monitor the total number of people in receipt of residential / nursing care which gives a better measure than admissions.
- Continue to explore potential to provide more nursing support in the community to address the issue that admissions to nursing care (specifically dementia nursing care) are increasing, while admissions to residential care are decreasing.
- Continue to explore alternative options to support people with dementia in the community e.g. through shared living schemes which maintain a greater degree of independence.

Key BCF Schemes to target this:

- Reablement
- Assistive Technology
- Enhanced Early Intervention Service
- Housing Related Support
- Carers Support
- Transitional Care
- Low Level Support
- Day Services
- Dementia Advisory Service
- Disabled Facilities Grants
- SPA (appendix 8)

2.4 Reablement/ Rehabilitation Services

Current position: Achieving against the 2016/17 BCF plans.

Key Issues: The percentage of older people still at home 91 days after discharge into reablement / rehabilitation services is below target with year end performance of 76.2% against a target of 83.1%, however this is an improvement compared to performance of 70% earlier in the year. This indicator will continue to be closely monitored with work being undertaken to understand the reasons why some people are not still in their homes 91 days following discharge. It should be noted that this measure of the effectiveness of

reablement services only captures a small subset of the total number of people accessing reablement, with many people accessing the service from the community as a preventative measure. Local measures indicate that 583 reablement packages commenced in 2015/16 with 78.4% of people having no ongoing social care needs after a reablement intervention, and in 2016/17 94.1% of reablement goals had been achieved at the end of the period of reablement.

It is recognised that, on reflection, the target of 83.1% was very challenging and potentially unrealistic in the context of the complex needs of many people who are discharged from hospital into these services.

Key Actions:

- Audit has been undertaken to establish the reasons why 28.7% of people discharged into reablement / rehabilitation services were not still at home 90 days following discharge and the summary paper reporting will be shared when available.
- Actions to be agreed following results of audit, which may include a review of how people are deemed to have potential for reablement / rehabilitation to ensure that the correct cohort of people is captured within this indicator.
- Other measures that demonstrate the effectiveness of reablement services will continue to be monitored. This measure of the effectiveness of reablement services only captures a small subset of the total number of people receiving reablement support, with many people accessing the service from the community as a preventative measure. Data indicates that 583 reablement packages commenced in 2015/16 with 78.4% of people having no ongoing social care needs after a reablement intervention and 91.5% of reablement goals achieved at the end of the period of reablement.

Key BCF Schemes to target this:

- Reablement
- Assistive Technology
- Enhanced Early Intervention Service
- Housing Related Support
- Carers Support
- Low Level Support
- Day Services
- Education and Training into Care Homes (appendix 6)
- McKenzie House pilot (appendix 7)
- SPA (appendix 8)
- Pharmacy Support into Care Homes (appendix 9)
- Integrated Digital Care records (appendix 11)

2.5 Delayed Transfers of Care (DToCs)

Q4 position: Not achieving against the 2016/17 BCF plans.

Key Issues: During Q4 2016/17 there were 1,138 delayed days against a planned 250 delayed days, this was a reduction of 942 from Q3. Of these:

- 993 delayed days were reported as being the responsibility of the NHS (decrease of 211 on Q3)
- 145 days were reported as the responsibility of social care (a decrease of 713 on Q3)
- 0 days were the responsibility of both

There has been a substantial increase in delays reported as the responsibility of social care from September 2016 onwards, although it should be noted that this is a result of the Foundation Trust recording and attributing delays differently from 1 September 2016. This change in approach has been formally challenged by the Local Authority and it has been agreed that returns from September 2016 onwards will be reviewed and resubmitted. This work has been completed and it has been confirmed by the FT that the revisions proposed by HBC have been agreed. The revised figure for delays attributed to HBC is 30 days for the period June 2016 – March 2017. The FT advised in July 2017 that they are experiencing difficulties uploading the revised information retrospectively to NHSI, so this has not yet been completed.

Delays reported due to NHS substantially increased from May 2016.

In Q4 2016/17 the main reasons for the delays were:

- Awaiting Nursing Home Placement or availability (345 days)
- “Patient or family choice” (234 days)
- Awaiting completion of Assessment (230 days)

A key challenge over the past 12 months has been availability of nursing home beds, which accounts for 44% of delays for the year. This position is expected to improve in 2017/18 with new nursing home provision available from May 2017 and two potential further developments later in the financial year. There will continue to be a pressure in relation to dementia nursing beds until these proposed new developments become operational.

Key Actions:

- Continued partnership working between CCG/HBC NTHFT, including social care staff working as part of the new Integrated Discharge Team, development of Integrated Discharge Pathways, a Discharge to Assess / Trusted Assessor pilot for the elective orthopaedic pathway and development of the Home from Hospital service.
- Monitor effectiveness of Choice policy
- Monitor discharge to assess work
- Continue the work to resolve the issue of nursing bed provision.

Key BCF Schemes to target this:

- Discharge to Assess / DToC (Appendix 2, 3)
- Home from Hospital Service (Appendix 10)

2.6 Non-Elective Admissions

Q4 position: Not achieving against the 2016/17 BCF plans

Key Issues: When reviewing the data across 2015/16 and 2016/17 the increase in non-electives has been across all age bands:

- 0-19: 14.2% increase
- 20-64: 16.8% increase
- 65+: 7.8% increase

To note – the smallest percentage increase has been within the 65+ cohort and this increase is less than in Q3.

There has been an overall increase in Non-Elective admissions of 1,464 admissions (12.6%) with a total cost increase of £2,497,095 (+12.6%). Only £989,061 (8.5%) of this is aligned to the over 65s cohort.

A more in-depth analysis of non-elective admissions (**See Appendix 5**) in the over 65s has identified that the main increases are in;

- **Thoracic procedures and disorders (mainly Pneumonia, COPD or unspecified Acute Lower Respiratory Infection)** with the highest number of admissions in 2016/17 with 1,060 compared to 944 in 2015/16. Winter increases in admissions peaked in February in both years with 105 admissions in February 2016 and 122 admissions in February 2017.
- **Nervous system procedures and disorders** - saw the largest percentage increase in cost in 2016/17 of 22.3% compared to 2015/16.

Key Actions - Thoracic

- Continue to link into work ongoing within Primary Care to address the uptake of the Pneumococcal Vaccination in both care homes and people in their own homes. GP Practice audits have highlighted the lack of take up or renewal of Pneumococcal vaccinations.
- From November 16, the Bed Bureau service has developed a script with the Hospital at Home service to support the conversations with GPs in relation to admissions for patients with a Respiratory condition and to offer/ suggest the Hospital at Home service as a more appropriate alternative.

Key Actions – Renal

- Circulate the integrated UTI guidance based on NICE to Care homes advising that adults aged 65 years and over have a full clinical assessment before a diagnosis of urinary tract infection is made. The guidance recommends that ‘carers do not dip’ to prevent the practice of random dipping of urine to diagnose UTI in the elderly which is not considered clinically effective. The holistic assessment of the resident will ensure the accuracy of UTI diagnosis and prevent unnecessary prescribing of antibiotics.
- The Care Home Training and Education Programme commenced at the end of February, with the first quarter’s report shown in appendix 7. The “Wellbeing” element of the training includes the importance of hydration in residents, cleanliness and general wellbeing to help in the prevention and early detection of UTIs.
- Since September 2016 Community Matrons have been aligned to care homes and aims to have a further impact on UTIs, and they are also supporting the “Wellbeing” element of the Care Home Training programme.
- Clinical Triage in the SPA was implemented in August 2016 and will support care homes in what to do when residents become unwell.

Key BCF Schemes to target this:

- McKenzie House Pilot (appendix 7)
- Care Home Training Programme (appendix 6)
- SPA (appendix 8)
- Pharmacy into Care Homes (appendix 9)
- Integrated digital care records (appendix 11)

2.7 Estimated diagnosis rate for people with dementia

Q4 position: Achieving against the 2016/17 BCF plans.

Key Issues: Achieving targets – Planned to have 909 individuals identified and placed on the dementia register, with an actual year end snap shot position of 897 (-12 below target).

Key Actions: Continue to identify individuals with dementia and ensure the dementia register is maintained.

3.0 LOCAL PERFORMANCE FRAMEWORK

LOCAL PERFORMANCE FRAMEWORK (Local Authority position at 29/01/2017)

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Protection of Social Services <ul style="list-style-type: none"> • Support for Sensory Loss & Long-Term Conditions (£100k) • Assistive Technology (£162k) • Housing Related Support (£329k) • Low Level Support Services (£124k) • Support for Existing Social Care (£747k) • Multi-link Reablement & Direct Care & Support (£526k) • Early Intervention Model inc Community Based Packages (£228k) • Transitional Care inc West View Lodge (£300k) • Telecare Expansion (£131k) • Maintain Existing Social Care Services 2016/17 (£211k) • Dementia Day Services (£86k) • Dementia Advisory Service (£60k) • Carers Support - Direct Payments (£75k) • Hartlepool Carers (£150k) 	<p>This level of funding was determined based on the original NHS Transfer to Social Care in 2013/14 of £2.3m which continued to maintain existing services supporting timely hospital discharge, delivery of reablement and telecare services, commissioning of low level services, support for ongoing care packages in the community and support for carers. The 2015/16 plan identified further funding of approximately £700k which was invested in protecting adult social care services which would otherwise be at risk. These services include low level services to support people with long term conditions and sensory loss, and assistive technology services that support people to remain independent in their own homes. This level of funding has been maintained in 2016/17 and increased to £3.198m to further support adult social care services that would otherwise be at risk.</p>	<p>Reduction in admissions to residential care -</p> <p>Service user and carer satisfaction -</p> <p>Proportion of older people (65 & over) still at home 91 days post discharge -</p> <p>Delayed transfers of care -</p> <p>Decreasing likelihood of hospital admission</p>	<p>NI136 People supported to live independently through social care (all adults)</p> <p>P008 Older people helped to live at home</p> <p>ASCOF 1C Proportion of clients have personal budgets and/or direct payments</p> <p>NI125 Achieving independence for older people through rehabilitation/ intermediate care</p> <p>ASCOF 1D Carer related quality of life</p>	<p>3,025 clients supported to live at home.</p> <p>0 delayed transfers of care attributable to HBC (prior to FT change to classification of reasons for delay from 01.09.16 - which is disputed). Over 2,200 individuals in receipt of assistive technology/telecare. Approx 156 carers received direct payments in the last year.</p> <p>583 reablement packages were started in 2015/16 with 78.4% of people having no ongoing social care needs following provision of a completed reablement package and 91.5% of reablement goals achieved at the end of a period of reablement.</p>

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Care Act Implementation	National funding allocation to support implementation of the Care Act (2014).	Reduction in admissions to residential care - Service user and carer satisfaction - Proportion of older people (65 & over) still at home 91 days post discharge - Delayed transfers of care - Decreasing likelihood of hospital admission	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home ASCOF 1C Proportion of clients have personal budgets and/or direct payments NI125 Achieving independence for older people through rehabilitation/ intermediate care ASCOF 1D Carer related quality of life	3,025 clients supported to live at home. 0 delayed transfers of care attributable to HBC (prior to FT change to classification of reasons for delay from 01.09.16 - which is disputed). Over 2,200 individuals in receipt of assistive technology/telecare. Approx 156 carers received direct payments in the last year. 583 reablement packages were started in 2015/16 with 78.4% of people having no ongoing social care needs following provision of a completed reablement package and 91.5% of reablement goals achieved at the end of a period of reablement.
Disabled Facilities Grant	National allocation to fund Disabled Facilities Grants (DFGs) that enable people to live independently in their own homes.	Reduction in admissions to residential care - Service user and carer satisfaction	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home ASCOF 1D Carer related quality of life	158 DFGs completed as at end of Q3 of 2016/17.

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
HBC - Increased Demand/New Provision				
Independent Sector Provision/Packages	HBC provides social care packages in the community to residents aged 65+ who meet the criteria for social care assessment and support. These packages include home care services, access to day services, extra care housing schemes or direct payment packages. The BCF provides a contribution to this service to allow for people, where possible, to remain within their own home with reduced likelihood of hospital admission. Low level services are utilised where appropriate to meet identified needs and support independence, there will always be a need for more intensive support, particularly in the context of an ageing population and increasing co-morbidities.	Reduction in admissions to residential care - Service user and carer satisfaction	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home ASCOF 1C Proportion of clients have personal budgets and/or direct payments	3,025 clients supported to live at home. Approximately 5,000 hours of domiciliary care provided per week.
Enhanced Early Intervention Services	Funding contributes towards a number of key areas within social care, including first point of contact, social work and Occupational Therapy, supporting an approach that diverts people from social care where appropriate and facilitating in depth assessments to ensure the service user is given access to the most appropriate services to meet with their need.	Proportion of older people (65 & over) still at home 91 days post discharge - Delayed transfers of care	NI125 Achieving independence for older people through rehabilitation/ intermediate care NI136 People supported to live independently through social services	0 delayed transfers of care attributable to HBC (prior to FT change to classification of reasons for delay from 01.09.16 - which is disputed).

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Early Intervention - Community Based Packages	HBC provides social care packages in the community to residents aged 65+ who meet the criteria for social care assessment and support. These packages include home care services, access to day services, extra care housing schemes or direct payment packages. The BCF provides a contribution to this service to allow for people, where possible, to remain within their own home with reduced likelihood of hospital admission. Low level services are utilised where appropriate to meet identified needs and support independence, there will always be a need for more intensive support, particularly in the context of an ageing population and increasing co-morbidities.	Reduction in permanent admissions to residential care - Service user and carer satisfaction	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home ASCOF 1C 89.2% of clients have personal budgets and/or direct payments	3,025 clients supported to live at home. Approximately 5,000 hours of domiciliary care provided per week.
West View Lodge - Rehab beds & price increase	Previous CCG contribution for rehabilitation beds, additional funding agreed in 16/17 to support increased negotiated price.	Reduction in permanent admissions to residential care - Service user and carer satisfaction - Delayed transfers of care	NI136 People supported to live independently through social care (all adults)	20 beds - revised contract uses transitional & rehabilitation capacity flexibly to support local need. Current utilisation is approximately 80-85%. Over 150 people supported per year.
Assistive Technology - expansion of service	Funding agreed as part of the former NHS transfer to social care to support a previous expansion of the Telecare service. This has now been superseded by subsequent expansion plans (including supervisor cover 24 hrs/day) with over 2,200 people now receiving assistive technology / Telecare support.	Reduction in emergency admissions - Reduction in permanent admissions to residential care - Service user and carer satisfaction	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home - P051 Access to equipment & telecare: users with telecare	Over 2,200 individuals in receipt of assistive technology/telecare.

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
LLS Day Service & Handy Person (old CCG contribution)	Support for lower level services including: Hartfields older person social inclusion service, Handy Person service and signposting service.	Reduction in permanent admissions to residential care - Service user and carer satisfaction	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home	Average attendance of 120 sessions per week at Social Inclusion service. 550+ individuals used Handy Person service with 850 minor repairs/adaptations completed. Further 600 referrals to Signposting Service.
Information & Advice	Support for Hartlepool Now web based information system. Trusted Assessor role within Occupational Therapy Service, implementation of mobile working for social care staff.	Reduction in permanent admissions to residential care - Service user and carer satisfaction	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home	Hartlepool Now had 1,290 users, 1,600 sessions and 4,070 hits.
Dementia Social Work	Additional social workers employed to support individuals living with dementia - one in each locality team.	Reduction in permanent admissions to residential care - Service user and carer satisfaction	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home	Approximately 1,200 older people living with dementia expected to rise to 1,800 by 2030. Approximately 270 in EMI residential & nursing placements.
Dementia Day Services (old CCG Contribution)	Contracted service via the Hospital of God. This provides day opportunities to people with dementia, providing respite to carers to maintain their caring role.	Reduction in permanent admissions to residential care - Service user and carer satisfaction - Decreasing likelihood of hospital admission	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home	The service supports approximately 30 people per day. 4,048 hrs of support provided within people's own homes in addition to building based day service.
Greenfields (Carers short breaks)	Contracted building based respite service that provides respite for individuals with a Learning Disability providing support to elderly carers.	Reduction in permanent admissions to residential care - Service user and carer satisfaction	NI135 Carers receiving assessment/review & a specific carer's service or advice & info ASCOF 1D Carer related quality of life	6 bed facility with one emergency bed. Operating at approx. 85% occupancy. Service rated by CQC as good in June 2015. Approx. 1,020 respite placements take place each year at Greenfields Lodge.

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Weekend Cover - Home Care	Payments made to the two home care providers to offer additional capacity in line with 6 day working scheme and bank holiday cover, to support with timely restarts and discharges from hospital.	Delayed transfers of care - Reduction in readmissions - Also contributes towards delivery of seven day services	NI136 People supported to live independently through social care (all adults) P008 Older people helped to live at home	Data being collated re: weekend referrals.
Co-location at UHH	HBC staff co-located at UHH site with FT staff to ensure an integrated approach to working in line with BCF framework and five year forward view. Funding supports costs of lease, phones etc.	Delayed transfers of care	P008 Older people helped to live at home NI125 Achieving independence for older people through rehabilitation/ intermediate care	0 delayed transfers of care attributable to HBC (prior to FT change to classification of reasons for delay from 01.09.16 - which is disputed). There were 2352 referrals into ASC in the first 9 months of 2015/16 plus 720 DOLS referrals, and 85 Safeguarding referrals.
Expert Carer Programme	Family leadership course with those living with Dementia - designed to consult & involve users and carers in policy & decision making. Ensures ownership of condition and seeks to develop transferable skills within the community	Reduction in permanent admissions to residential care - Service user and carer satisfaction - Decreasing likelihood of hospital admission	NI136 People supported to live independently through social care (all adults) - P008 Older people helped to live at home	Family leadership course established with strong links to North of Tees dementia Collaborative and Dementia Friendly Hartlepool agendas.
Carers Support - Direct Payments	Contribution towards the overall cost of direct payments for carers, enabling them to meet their needs and access short breaks in a flexible manner.	Reduction in permanent admissions to residential care - Service user and carer satisfaction - Decreasing likelihood of hospital admission	NI135 Carers receiving assessment/review & a specific carer's service or advice & info - ASCOF 1D Carer related quality of life	Approx 156 carers received direct payments in the last year. Target for carers receiving DPs 20% - currently year end projection 67%.
CCG Provision				

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Clinical Triage into SPA	The Single Point of Access (SPA) service is aimed at the over 65 population, but will also cover all adults in the Stockton-on-Tees and Hartlepool area and will therefore benefit the wider population. BCF has funded a clinical triage nurse to work within this service. The SPA service is open 7 days per week, offering a holistic health and social care assessment and is the first point of contact for both members of the public and health care professionals. This prevents duplication in service delivery and ensures that the most appropriate service is deployed to meet the individual's needs.	Non-elective Admission Avoidance Proportion of older people (65 and over) who were still at home 91 days after discharge into reablement / rehabilitation services	Secondary Care admission avoidance Care home admission avoidance Increased community based treatment of LTC's Increased positive experience of care Reduced average length of stay Reduced overall cost in low level services Increased patient choice: dying in preferred place	HBC: (Pop 72,627) SBC:(Pop 151,654) See Appendix 8
Recurrent Investment into Community Services	Additional investment as per maintaining and protecting existing NHS Community Services below:			
Community Service input into West View Lodge	The Service Specification was for a pilot of West View Lodge Rapid Assessment Intervention Team (RAIT) that would form part of the existing MDT already in place within West View. The additional service provision was to provide nursing support as well as additional therapy support alongside the existing physiotherapists, occupational therapists and support workers providing nursing and therapy led interventions working across a seven day model to a total number of 20 beds.	Non-elective Admission Avoidance Proportion of older people (65 and over) who were still at home 91 days after discharge into reablement / rehabilitation services Long-term support need of older people (65 and over) met by admission to residential and nursing care homes Delayed transfers of Care	Integration of Health and Social Care Improvement in quality of life outcomes as measured by the patient life experience using validated tool Reduction in length of stay within WVL by patients receiving appropriate rehab and nursing support and being safely discharge home (by CIAT team). 13/14 baseline: LOS on average 19 days. Reduction of 5% in LOS (i.e. reduce average LOS to 18 days) Reduction in length of stay within Rosedale by patients receiving appropriate rehab and nursing support and being safely discharge home	Finance & BI advised that activity for West Lodge is not separately identified but included in CIAT data.

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
			(by CIAT team). Reduction in readmissions (or ambulatory care re-attendance) within 30 days from West View Lodge (Expectation of 5% improvement each quarter) Achieving independence for older people through rehabilitation/intermediate care Length of stay within Rosedale rehabilitation unit	
Maintaining and protecting existing NHS Community Services	<p>During the 2014/15 contract negotiations it was flagged by the community services provider, North Tees and Hartlepool NHS Foundation Trust, that the costs of running the contract were circa £3.8m above the contract value. A review of Community Services was undertaken during 2014/15 to identify the issues that were causing the funding gap. The CCG negotiated these differences during the 2015/16 contracts and agreed a recurrent increase on the contract of £951k, which broken down by locality level, equates to an investment of £317k for Hartlepool locality.</p> <p>The bulk of the agreed investment was in the Single Point of Access Team, Community Integrated Assessment Team and the Teams Around the Practices (including Community Matrons). These are the Community Teams that are integral to the achievement of the Hartlepool Better Care Fund Plan and have also been co-located with Social Care services at the Hartlepool Hospital site. The investment into these services was required to sustain the existing services for them to be able to support the new integrated ways of working.</p>	<p>Non-elective Admission Avoidance</p> <p>Proportion of older people (65 and over) who were still at home 91 days after discharge into reablement / rehabilitation services</p> <p>Long-term support need of older people (65 and over) met by admission to residential and nursing care homes</p> <p>Delayed transfers of Care</p>	7 day working	Separate service breakdown would be necessary

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Enhanced Pharmacy Scheme	<p>NECS would deliver the following service:</p> <ul style="list-style-type: none"> • Development, management and validation of self-assessment audits, • Provision of advice around Medicines policy , • Work with key stakeholders and support information sharing which will include learning from medicine incidents, • Provide specialist medicines optimisation advice and respond to queries in support of Adult Care Teams with regard to legislation and best practice around the prescribing, supply, dispensing, storage and administration of medicines within care settings, • Provide specialist, bespoke training, for all care teams, tailoring material to address the needs of the individual teams, which includes induction and on-going update training including on safe management of controlled drugs, MAR charts and catheter product management. • Production of quarterly reports evidencing Service delivery and progress against agreed key performance indicators for the Service, • Attendance at domiciliary care forums, • Referral of patients for full medication reviews to the care home service delivery already commissioned during 15/16. 	<p>No-elective Admission Avoidance</p> <p>Long-term support need of older people (65 and over) met by admission to residential and nursing care homes</p>	<p>Safe medicines management Prevention of home closures Improved support to Care Homes A reduction in hospital admissions. A reduction in re-admissions. An improvement in patient satisfaction Increased staff satisfaction and retention</p>	<p>22 Care Homes, 4 Domiciliary Care Providers</p> <p>See Appendix 9</p>

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Community Dementia Liaison Service	<p>A Dementia Liaison Service and Specialist Mental Health Worker-Dementia currently operate in Hartlepool with two different providers and works in silo to other integrated services. It is a 9-5 service with a focus on supporting early discharge from hospital with an element of crisis management in the community.</p> <p>Work is ongoing to review these services .</p>	<p>Non-elective Admission Avoidance</p> <p>Proportion of older people (65 and over) who were still at home 91 days after discharge into reablement / rehabilitation services</p> <p>Delayed transfers of Care</p> <p>Estimated diagnosis rate for people with dementia</p>	<p>Reduce emergency admissions for people with dementia</p> <p>Reduce emergency readmissions for people with dementia</p> <p>Improve quality of care</p> <p>Provide care closer to home</p> <p>Reduce length of stay in hospitals</p>	<p>Q4 Dementia report:</p> <p>Average Length of Stay (ALoS) following non-elective admission for patients with and without a dementia diagnosis:-</p> <ul style="list-style-type: none"> - During 2015/16 the ALoS for patients with dementia was 16.9 days, compared to 9.2 days for patients without a dementia diagnosis (+85%) - During 2016/17 the ALoS for patients with dementia was 19.4 days, compared to 8.1 days for patients without a dementia diagnosis (+140%) <p>Short-stay admissions can be particularly traumatic for patients with dementia - monitoring - LoS for 0 days, 1 day and >1 day following emergency admission:-</p> <p>During 2015/16, 18.8% of admissions for patients with dementia were for <=1 day</p> <p>During 2016/17, 20.3% of admissions for patients with dementia were for <=1 day</p>

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
Carers Support	<p>To enable carers to continue in their caring role with appropriate assessment, support and services available.</p> <p>To support carers and reduce admissions to care homes and / or hospital as a result of carer breakdown.</p> <p>The number of informal carers continues to grow, and an increasing number of people are accessing carers assessments and requesting services, either through the voluntary sector or via Direct Payments.</p>	<p>Non-elective Admission Avoidance</p> <p>Proportion of older people (65 and over) who were still at home 91 days after discharge into reablement / rehabilitation services</p> <p>Delayed transfers of Care</p>	<p>A reduction in hospital admissions.</p> <p>A reduction in re-admissions.</p> <p>A reduction in delayed transfers of care</p> <p>A reduction in number of admissions to care homes</p> <p>An improvement in patient satisfaction</p> <p>Increased staff satisfaction and retention.</p>	<p>Hartlepool Carers' position at 31/03/2017:</p> <p>Number of patients recorded as being a carer <18 years = 67 (compared with 47 at end of Q3)</p> <p>Number of patients recorded as being a carer >=18 years = 3064 (compared with 2851 at end of Q3)</p>
Training & Education into Care Homes	<p>To provide clinical education and training to support the staff employed by care homes with the aim of empowering the registered and non-registered staff to make confident informed decisions around residents care, resulting in avoidable admissions into hospital and enhancing the residents and staff experience.</p> <p>It is proposed that a group of organisations co-ordinated by the Education and Organisation Development department within North Tees and Hartlepool NHS Foundation Trust will work with care homes to provide this training. The 2016/17 pilot will form a basis for on-going investment across the sector to ensure sustainability and delivery of high quality clinical care for people who reside in a care home.</p> <p>Included within this training programme is Falls prevention training provided by Stockton and Hartlepool Borough Councils; Palliative and end of life care training in conjunction with Hartlepool & District Hospice; Dementia and Delirium training provided by TEWV; the use of digital technology to</p>	<p>Non-elective Admission Avoidance</p> <p>Proportion of older people (65 and over) who were still at home 91 days after discharge into reablement / rehabilitation services</p> <p>Long-term support need of older people (65 and over) met by admission to residential and nursing care homes</p> <p>Delayed transfers of Care</p>	<p>Local defined outcomes</p> <ul style="list-style-type: none"> • Increase in staff's confidence and understanding of how to quickly identify and respond to a deteriorating resident • Improved quality of care within care homes • Increase in calls to the Single Point of Access and the use of services commissioned to support the care home sector • Increased satisfaction and retention of care home staff • Improved Palliative/ End of Life care including an increase in recording and deaths in residents preferred place of care • Improved Falls prevention and management • Improved knowledge and management of residents 	<p>Clinical Education & Training Programme commenced February 2016.</p> <p>See Appendix 6</p>

Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
	capture electronically National Early Warning Scores (NEWS) to help to proactively manage people's care.		with Dementia and Delirium <ul style="list-style-type: none"> • Reduction in A&E attendances from Care Homes • Reduction in Emergency Admissions from Care Homes • Reduction in Emergency Admissions from Care Homes which end with the patient dying specifically those who die within 0<24 and 24-<48 hours 	
Home from Hospital Service	<p>This initiative centres on co-ordinating care within an acute setting, eliminating unnecessary length of stay in hospital in order to free up beds and facilitate appropriate discharge back to individuals homes. It involves partnership working with the Integrated Discharge to assess team, working closely with the acute hospital services including wards, accident & emergency, GP practices, district nurses, local authority and the Hospital of God as service provider. This is an innovative approach to an old problem and a pressing one that is on-going. Older patients who are frail or socially isolated (some of whom may have dementia) can do less well in hospital due to communication and cognitive difficulties. The Hospital of God can fill some of these gaps by providing support pre and post discharge to people not known to social services up to 7 days as part of the discharge to assess pathway to people going back to their own home. The service can be accessed by people aged over 65 who live in the Borough of Hartlepool who</p>	<p>Non-elective Admission Avoidance</p> <p>Proportion of older people (65 and over) who were still at home 91 days after discharge into reablement / rehabilitation services</p> <p>Delayed transfers of Care</p> <p>Estimated diagnosis rate for older people with dementia</p>	<p>Contribute to the reduction of inappropriate admissions and re-admissions to hospital and care homes</p> <p>Contribute to the reduction of delayed transfers of care in the acute setting by supporting the discharge to assess pathway</p> <p>To work with the integrated discharge team in identifying appropriate patients</p> <p>Care for an ageing population in an acute setting to support and facilitate a speedier discharge</p> <p>Bring care closer to home</p> <p>Medication optimisation</p> <p>Signpost to specialist advice and support</p> <p>Improved quality of life</p>	<p>Service commenced 8th May with a revised Service Specification.</p> <p>Appendix 10</p>

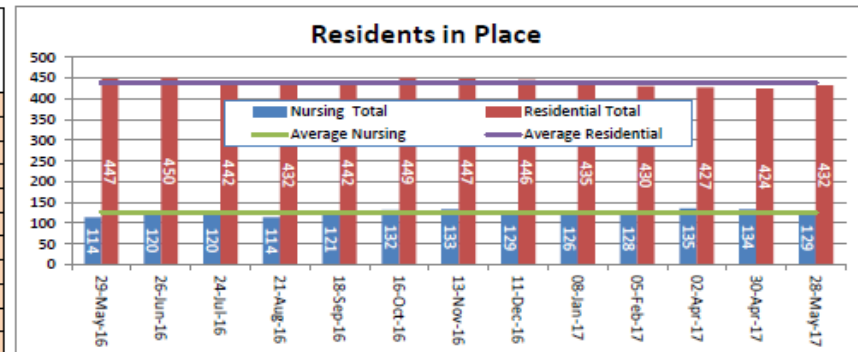
Scheme	Summary	Key BCF Indicators	Local Performance Indicators	Activity
	may find themselves in a hospital environment who are without family support and are doing less well due to sensory loss, general frailty and more complex needs following a stroke, cardiac issues and other co-morbidity factors. It will support carers as well who may be elderly and struggle to cope and become ill themselves, thus preventing carer crisis.		Access to health promotion information and education	

APPENDIX 1: Care Home activity

Residential & Nursing Summary Activity Report (Older People) - May 2017

Number of People in Place in Residential & Nursing Care

	Number of People in Place (Snapshot) by Type of Stay (65+)													Average	Annual % Change
	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17		
Nursing	Permanent	100	98	98	97	102	107	111	106	106	108	110	106	104	6%
	Short Term Breaks	0	0	1	0	0	0	0	0	0	0	0	0	0	0%
	Short Stay	14	22	21	17	19	25	22	23	22	27	24	23	22	64%
	Nursing Total	114	120	120	114	121	132	133	129	128	135	134	129	126	13%
Residential	Permanent	354	360	358	362	363	377	379	375	362	359	360	358	365	1%
	Rehab	5	3	4	4	6	5	4	5	3	0	0	0	3	-100%
	Short Term Breaks	3	7	11	4	4	6	9	6	3	6	1	4	5	33%
	Short Stay	75	71	62	55	62	54	49	54	46	50	57	61	58	-19%
	Resid Transition Service	10	9	7	7	7	7	6	6	6	9	10	6	9	-10%
	Residential Total	447	450	442	432	442	449	447	446	435	427	424	432	439	-3%
	Nursing & Resid Total	561	570	562	546	563	581	580	575	561	562	558	561	564	0%



1a Year End Position

	2013-14	2014-15	2015-16	2016-17	2017-18	% 4 Year Change
Nursing	136	129	112	135	129	-5%
Residential	436	430	442	427	432	-1%
Total	572	559	554	562	561	-2%

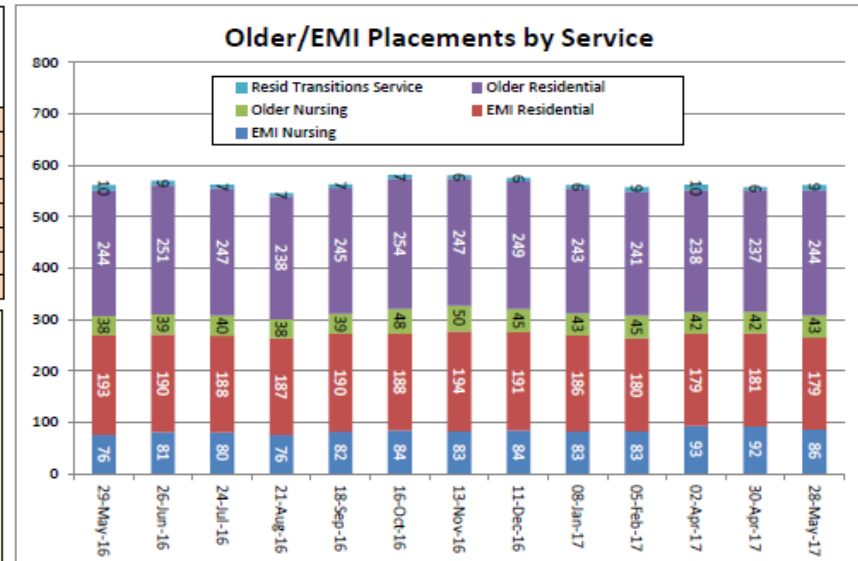
Number of People in Place (Snapshot) by Type of Stay (65+):

The table above is based on information from the Supported Residents report, which looks at data on a 4 weekly basis (in line with residential payment runs). Horizontal lines on the chart are averages over the period. These tables only includes care management over 65's and excludes LD clients who may be over 65.

The overall number of people in over 65 places is the same as a year ago, with a peak of 581 people in Oct 2016. There has been an increase in nursing placements from 114 to 129 (increase of 13%), while residential placements have decreased from 447 to 432 over the same period (3% drop), although this is susceptible to changes on a monthly basis. Data over the last 3-4 years shows peaks and troughs for both residential and nursing, however compared to 4 years ago nursing placements are 5% down (136 to 129) while residential placements have also reduced by only 1% (436 to 432).

2 Number of Older People in Place (snapshot) by Service

	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Average	Annual % Change
EMI Nursing	76	81	80	76	82	84	83	84	83	83	93	92	86	83	13%
EMI Residential	193	190	188	187	190	188	194	191	186	180	179	181	179	187	-7%
Older Nursing	38	39	40	38	39	48	50	45	43	45	42	42	43	42	13%
Older Residential	244	251	247	238	245	254	247	249	243	241	238	237	244	244	0%
Resid Transitions Service	10	9	7	7	7	7	6	6	6	9	10	6	9	8	-10%
Nursing Total	114	120	120	114	121	132	133	129	126	128	135	134	129	126	13%
Residential Total	447	450	442	432	442	449	447	446	435	430	427	424	432	439	-3%
Total	561	570	562	546	563	581	580	575	561	558	562	558	561	564	0%

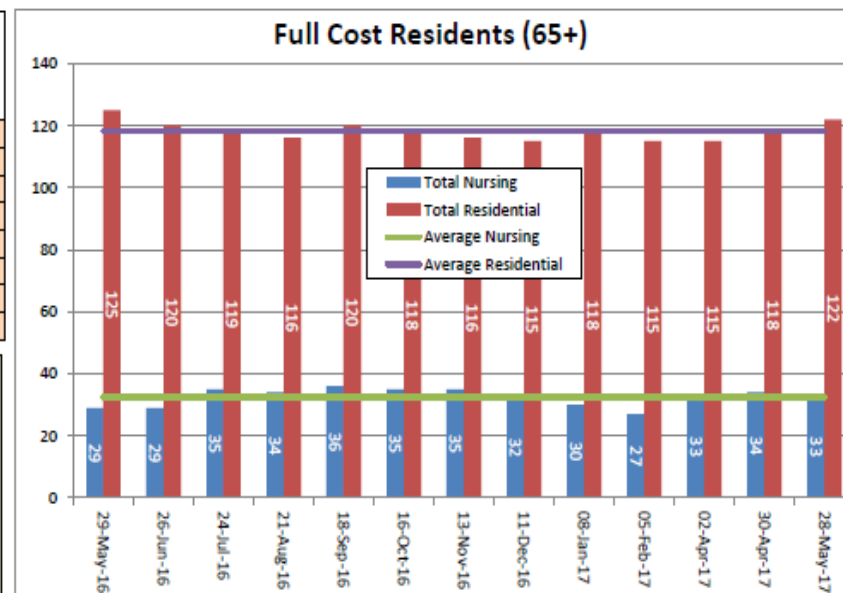


2a Year End Position

	2013-14	2014-15	2015-16	2016-17	2017-18	% 4 Year Change
EMI Nursing	81	86	75	93	86	6%
EMI Residential	161	180	192	179	179	11%
Older Nursing	55	43	37	42	43	-22%
Older Residential	263	244	242	238	244	-7%
Resid Transitions Service	12	6	8	10	9	-25%
Total	572	559	554	562	561	-2%

Number of People in Place (Snapshot) by Service: In May 2017, 432 people were in Older/EMI Residential care settings, which is less than the same period in the previous year (447, 3% drop). Conversely, 129 people were in Older/EMI Nursing in May 2017 compared to 114 the previous year (a 13% increase). Over the last 3-4 years, the number of EMI Residential placements has increased from 161 to 179 (11% increase), while Older Residential placements has reduced from 263 to 244 (7% decrease). EMI nursing has seen an increase from 81 to 86 (6% increase) over the last 4 years, however this has seen some peaks and troughs. Older Person Nursing has seen a decline from 55 to 43 placements (22% decrease) over the same period.

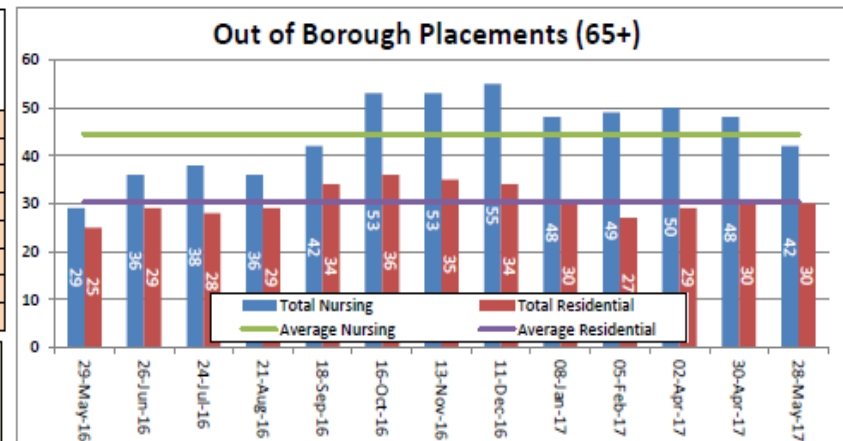
3	Number of Full Cost Residents (Snapshot, 65+)	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Average	Annual % Change
	EMI Nursing	17	17	19	19	20	18	19	17	16	14	20	22	21	18	24%
	EMI Residential	55	53	55	56	56	51	50	52	52	49	48	52	54	53	-2%
	Older Nursing	12	12	16	15	16	17	16	15	14	13	13	12	12	14	0%
	Older Residential	70	67	64	60	64	67	66	63	66	66	67	66	68	66	-3%
	Total Nursing	29	29	35	34	36	35	35	32	30	27	33	34	33	32	14%
	Total Residential	125	120	119	116	120	118	116	115	118	115	115	118	122	118	-2%
	Total	154	149	154	150	156	153	151	147	148	142	148	152	155	151	1%
	% Full cost of all	27%	26%	27%	27%	28%	26%	26%	26%	26%	25%	26%	27%	28%	27%	1%



3a	Year End Position	2013-14	2014-15	2015-16	2016-17	2017-18	% 4 Year Change
	EMI Nursing	19	17	16	20	21	10%
	EMI Residential	48	48	53	48	54	13%
	Older Nursing	18	8	10	13	12	-46%
	Older Residential	65	65	66	67	68	4%
	Total	150	138	145	148	155	3%

Full Cost Residents:
The number of full cost residents has increased slightly from 154 to 155 over the last year with a peak of 156 in Sept 2016. Data over the last 3-4 years, shows that apart from the total full cost residents falling during 2014-15 the other years are quite consistent and it is currently 3% more than 4 years ago. There has been variation over the last year by type of stay, e.g. EMI Nursing & residential have both increased, while Older Nursing has reduced significantly (but is smaller numbers). Older residential has only slightly increased (3%).

4	Number of Out Of Borough Placements (Snapshot, 65+)	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Average	Annual % Change
	EMI Nursing	20	24	25	25	31	34	32	36	33	33	35	35	30	30	50%
	EMI Residential	13	15	13	14	17	16	18	16	15	13	13	13	12	14	-8%
	Older Nursing	9	12	13	11	11	19	21	19	15	16	15	13	12	14	33%
	Older Residential	12	14	15	15	17	20	17	18	15	14	16	17	18	16	50%
	Total Nursing	29	36	38	36	42	53	53	55	48	49	50	48	42	45	45%
	Total Residential	25	29	28	29	34	36	35	34	30	27	29	30	30	30	20%
	Total	54	65	66	65	76	89	88	89	78	76	79	78	72	75	33%
	% OOB of all clients	10%	11%	12%	12%	13%	15%	15%	15%	14%	14%	14%	14%	13%	13%	33%



Out of Borough Placements:
Over 65s OOB placements have increased over the last year from 54 to 72 which is a 33% increase, but had peaked at 89 in both Oct & Dec. The majority of this increase is due to an increase in nursing placements i.e. 29 to 42 (45% increase). Residential placements also increased from 25 to 30 (a 20% rise), however this was solely due to the increase in older residential placements, not EMI.

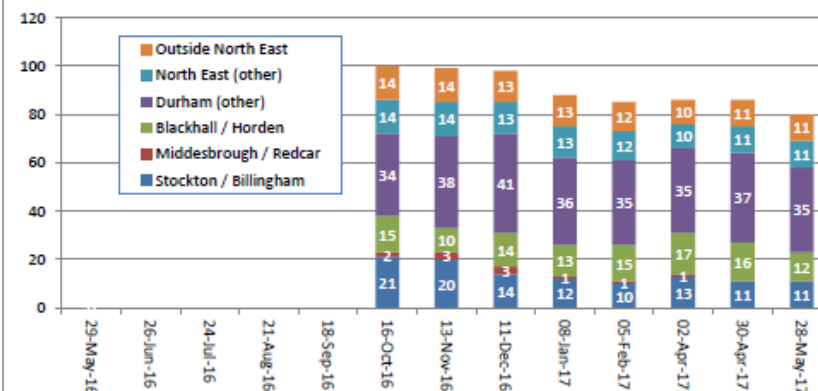
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Number of Out Of Borough Placements (Snapshot, 65+)	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Mar-17	30-Apr-17	28-May-17	Average	Average % Split
Stockton / Billingham						21	20	14	12	10	13	11	11	14	17%
Middlesbrough / Redcar	FURTHER INFO TO BE COMPLETED					2	3	3	1	1	1	0	0	1	2%
Blackhall / Horden						15	10	14	13	15	17	16	12	14	17%
Durham (other)						34	38	41	36	35	35	37	35	36	43%
North East (other)						3	3	4	3	3	3	3	3	3	4%
Outside North East						14	14	13	13	12	10	11	11	12	15%
Total	0	0	0	0	0	89	88	89	78	76	79	78	72	84	100%

Out of Borough Placements by Location:

The table above will be populated as we move forward over the coming months. 'Blackhall/Horden' have been separated from 'Durham (other)' as they are very close to Hartlepool. Durham (other) has the greatest population of Hartlepool out of borough placements in both terms of current placements (35), and the average percentage over the last eight periods (43%), which is more than double the next most utilised location, i.e. Blackhall/Horden (14). Other significant current locations include Stockton/Billingham (11) while there are currently also 11 placements outside of the North East for older people. If required, we do have the physical distances of the OOB placements from Hartlepool centre.

OOB Placements by Area (65+)



5

Occupancy / Capacity	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Mar-17	30-Apr-17	28-May-17	Average Occupancy	Current Capacity
Brierton Lodge (N)	58	58	58	58	58	58	58	55	57	57	57	58	58	58	58
Charlotte Grange (R)	46	44	43	46	46	46	44	45	43	45	42	40	46	44	46
Clifton House (R)	21	19	17	16	16	16	16	15	17	18	17	16	18	17	27
Dinsdale Lodge (R)	16	16	16	16	16	16	16	16	18	19	23	23	24	18	24
Elwick Grange (R)	59	57	60	59	59	59	59	60	54	57	58	57	58	58	60
Gretton Court (N)	37	37	36	37	37	36	37	36	35	36	36	37	36	36	37
Lindisfarne (R)	48	46	45	43	47	53	51	53	51	52	51	51	51	49	54
Queens Meadow (R)	56	56	55	58	57	55	56	55	56	55	55	54	57	56	59
Rossmere Park (N)	NEW HOME												4	4	20
Rossmere Park (R)	NEW HOME												2	2	30
Seaton Hall (R)	27	25	26	20	21	20	22	21	22	21	23	24	24	23	27
Sheraton Court (R)	80	80	80	80	80	80	78	80	80	78	80	79	80	80	80
Stichell House (R)	35	35	35	35	35	35	35	35	35	35	34	35	35	35	35
Warrior Park (N)	19	22	20	25	25	25	29	27	30	28	30	31	32	26	27
Warrior Park (R)	21	20	23	23	23	23	19	20	18	20	15	15	15	20	21
West View Lodge (R)	50	51	52	52	50	50	49	49	50	47	48	45	45	49	52
Wynyard Woods (R)	48	46	48	49	50	48	47	45	48	48	48	48	48	48	50
Nursing	114	117	114	120	120	119	124	118	122	121	123	126	130	121	
Residential	507	495	500	497	500	501	492	494	492	495	494	487	507	497	
Total	621	612	614	617	620	620	616	612	614	616	617	613	637	618	

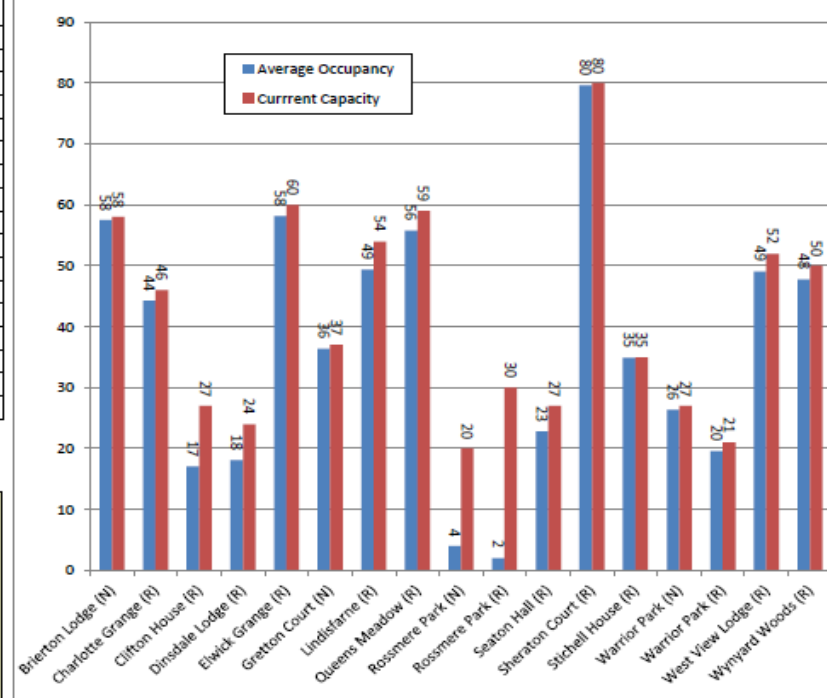
Average Occupancy/Capacity

(N) = Nursing placement. (R) = Residential placement. This occupancy data includes *all clients* not just HBC clients, e.g. will include private funders, fully funded health care clients and those placed from outside Hartlepool into Hartlepool homes.

There are a few homes where the average occupancy over the year is significantly less than their capacity, for example, Clifton House, Dinsdale Lodge and Seaton Hall. These are also the smallest homes in terms of capacity. Rossmere Park is a new home which has only just started taking in residents.

The current capacity figure (final column) is just the most recent capacity figure (note this could have changed during the year). Warrior Park has dual registration for its beds, therefore each bed can either be a residential bed or a nursing bed, therefore the current capacity split is only a guide.

Average Occupancy v Current Capacity



6

Usage Split in Hartlepool - Nursing & Residential		29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Average	% Usage
HBC - Nursing		85	84	82	78	79	79	80	74	78	79	85	86	87	81	79%
HBC - Residential		422	421	414	403	408	413	412	412	405	403	398	394	402	408	
Non-HBC - Nursing		29	33	32	42	41	40	44	44	44	42	38	40	43	39	20%
Non-HBC - Residential		85	74	86	94	92	88	80	82	87	92	96	93	105	86	
Total		621	612	614	617	620	620	616	612	614	616	617	613	637	616	
% non-HBC residents		18%	17%	19%	22%	21%	21%	20%	21%	21%	22%	22%	22%	23%	20%	

Usage Split in Hartlepool (Nursing & Residential):

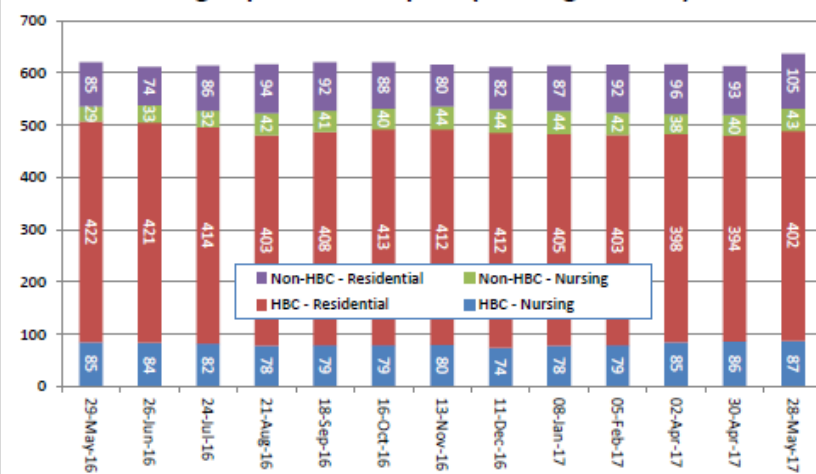
There is a slight increase in the number of HBC nursing placements from a year ago (2 people), however there was a significant trough between Aug-16 and Feb-17. HBC residential placements have declined from 422 to 402, with a peak of 422 in May 2017, resulting in an overall reduction over the year of 20 placements.

On average, HBC placements accounted for 79% of all nursing & residential placements in Hartlepool.

Non-HBC placements account for 20% (based on yearly averages) of all nursing & residential placements in Hartlepool and includes CCG, self funding and other LA placements. Non-HBC Nursing placements increased steadily over the year from 29 in May 2016 to 43 in May 2017. The non-HBC residential placements have increased significantly from 85 in May 2016 to 105 in May 2017, a 24% increase.

The final row shows the monthly proportion of clients who are in residential & nursing homes in Hartlepool who are not funded by HBC. This

Usage Split in Hartlepool (Nursing & Resid)



Residential & Nursing Summary Activity Report (Older People) - May 2017

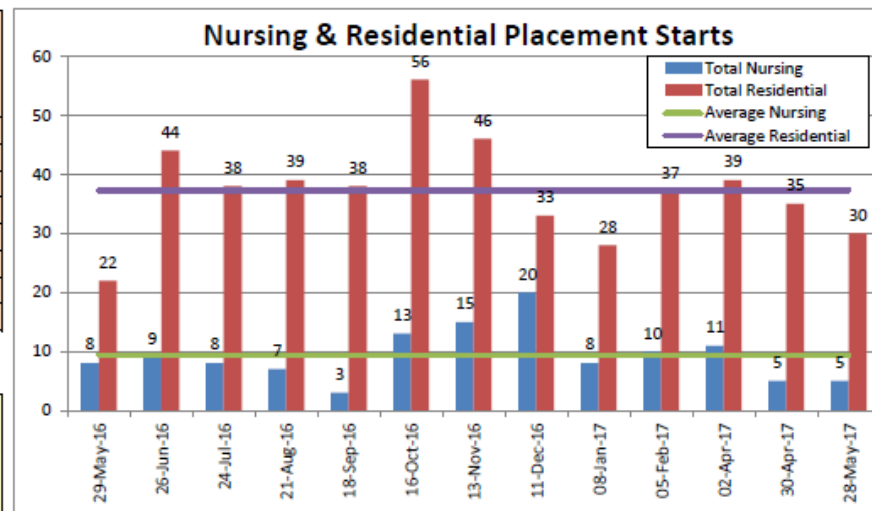
Starts & Permanent Admissions to Residential & Nursing Care (Older People)

7

Number of Starts in Period	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Total	Average	% of Total
EMI Nursing	2	6	6	4	1	6	8	6	5	5	4	3	3	59	5	10%
EMI Residential	4	10	12	9	20	22	20	5	8	11	13	14	5	153	12	25%
Older Nursing	6	3	2	3	2	7	7	14	3	5	7	2	2	63	5	10%
Older Residential	14	30	24	25	14	31	20	23	14	21	18	15	18	267	21	44%
Resid Transition Service	4	4	2	5	4	3	6	5	6	5	8	6	7	65	5	11%
Total Nursing	8	9	8	7	3	13	15	20	8	10	11	5	5	122	9	20%
Total Residential	22	44	38	39	38	56	46	33	28	37	39	35	30	485	37	80%
Total	30	53	46	46	41	69	61	53	36	47	50	40	35	607	47	100%
% Nursing of Total	27%	17%	17%	15%	7%	19%	25%	38%	22%	21%	22%	13%	14%	20%	20%	
% Residential of Total	73%	83%	83%	85%	93%	81%	75%	62%	78%	79%	78%	88%	86%	80%	80%	

Starts & Permanent Admissions in Period:

Starts includes transfers, new admissions, short stays, short to long stay moves etc.
Of over 65s, Older Residential (44%) and EMI Residential (25%) are the largest number of starts across the year.
There are on average 47 placements started/transferred each month, with 80% of these being in residential.

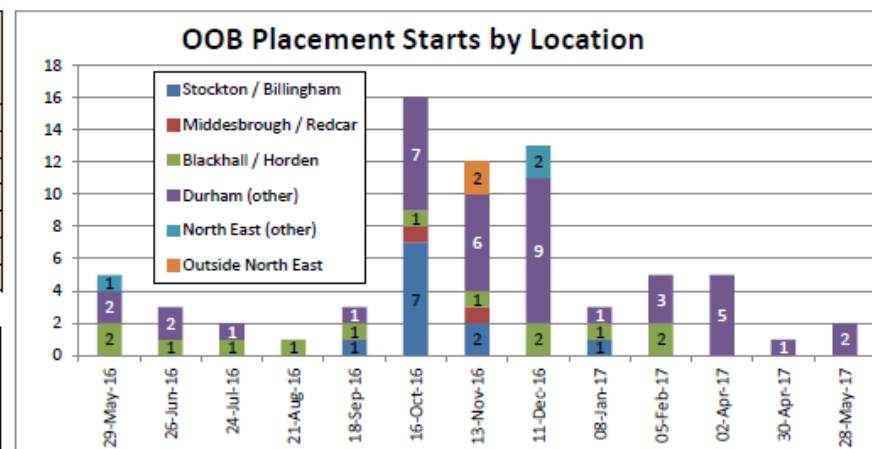


8

Number of OOB Starts by Location (Over 65s)	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Total	Average	% of Total
Stockton / Billingham	0	0	0	0	1	7	2	0	1	0	1	0	0	12	0.9	16%
Middlesbrough / Redcar	0	0	0	0	0	1	1	0	0	0	0	0	0	2	0.2	3%
Blackhall / Horden	2	1	1	1	1	1	1	2	1	2	0	1	1	15	1.2	20%
Durham (other)	2	2	1	0	1	7	6	9	1	3	5	1	2	40	3.1	54%
North East (other)	1	0	0	0	0	0	0	2	0	0	0	0	0	3	0.2	4%
Outside North East	0	0	0	0	0	0	2	0	0	0	0	0	0	2	0.2	3%
Total OOB Starts	5	3	2	1	3	16	12	13	3	5	6	2	3	74	5.7	100%
% OOB Starts of all starts	17%	6%	4%	2%	7%	23%	20%	25%	8%	11%	12%	5%	9%	11%		

OOB Starts in Period by Location:

Durham, including Blackhall & Horden (which are shown separate from Durham here), account for 74% (55) of all OOB starts, whereas Stockton/Billingham accounts for 16% (12). For older people, there have only been 3 placement starts in the wider North East (outside Tees & Durham) and only been 2 placement starts outside the North East area in the last year.
There was a big increase in OOB use in Oct, Nov & Dec 2016 - i.e. 16, 12 and 13 respectively.



9

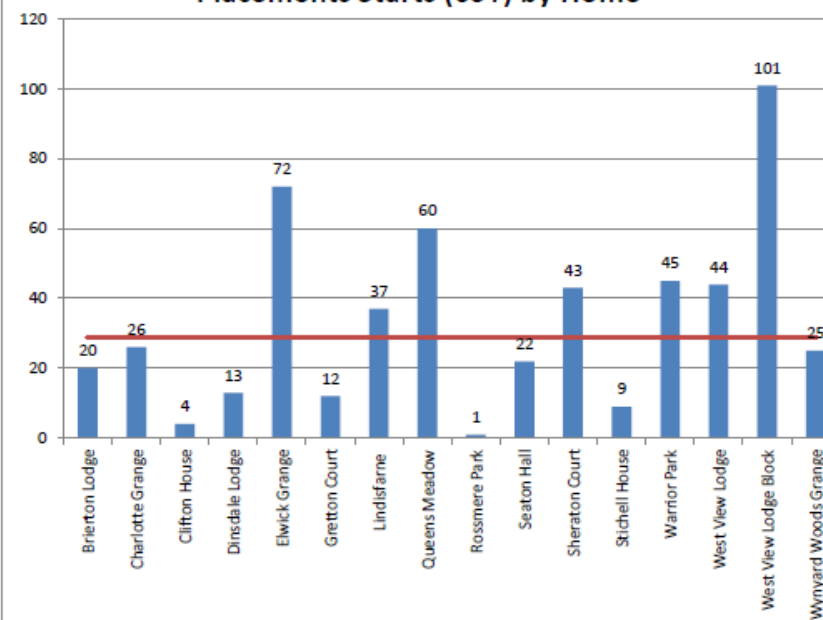
Number of Placement Starts by Home (65+)	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Total	Average	% of Total
Brierton Lodge	2	3	0	1	1	2	1	1	1	3	3	1	1	20	1.5	4%
Charlotte Grange	0	1	2	7	1	1	2	2	1	2	2	4	1	26	2.0	5%
Clifton House	0	1	0	0	0	0	0	0	2	0	0	0	1	4	0.3	1%
Dinsdale Lodge	0	1	0	0	1	0	0	0	1	2	4	2	2	13	1.0	2%
Elwick Grange	2	7	5	4	4	10	8	4	4	9	4	5	6	72	5.5	13%
Gretton Court	0	1	0	1	0	1	2	0	3	2	0	2	0	12	0.9	2%
Lindisfarne	1	0	1	1	10	6	1	4	3	5	2	1	2	37	2.8	7%
Queens Meadow	3	10	3	6	6	6	5	6	2	1	6	4	2	60	4.6	11%
Rossmere Park	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0.1	0%
Seaton Hall	0	3	3	0	0	1	2	3	2	1	4	2	1	22	1.7	4%
Sheraton Court	1	7	5	2	3	3	3	3	0	3	6	4	3	43	3.3	8%
Stichell House	1	0	3	2	0	2	0	0	0	0	0	0	1	9	0.7	2%
Warrior Park	3	5	8	5	0	3	7	3	1	1	3	4	2	45	3.5	8%
West View Lodge	3	3	5	3	5	7	4	3	3	1	2	2	2	44	3.4	8%
West View Lodge Block	8	7	7	11	7	8	9	9	8	8	7	6	6	101	7.8	19%
Wynyard Woods Grange	1	0	2	3	2	2	5	2	2	2	2	1	1	25	1.9	5%
Total	25	49	44	46	40	52	49	40	33	42	44	38	32	534	41.1	100%

Placements Starts by Home (65+):

The table above shows all 'in Hartlepool' starts for Older People, by home.

With the exception of the West View Lodge Block Bed (used for Transitional & Rehab cases), the largest numbers of 'placement starts' over this period are at Elwick Grange (72), Queens Meadow (60), Warrior Park (45), West View Lodge (44) and Sheraton Court (43) - accounting for 48% of starts across the town. The average line on the chart opposite excludes West View Lodge Block.

Placements Starts (65+) by Home



10

Number of Permanent Admissions by Type of Stay (65+)	29-May-16	26-Jun-16	24-Jul-16	21-Aug-16	18-Sep-16	16-Oct-16	13-Nov-16	11-Dec-16	08-Jan-17	05-Feb-17	02-Apr-17	30-Apr-17	28-May-17	Total	Average	% of Total
EMI Nursing	1	2	4	1	2	4	4	1	0	2	1	1	1	24	1.8	18%
EMI Residential	0	2	1	6	2	8	0	1	1	3	4	3	1	32	2.5	24%
Older Nursing	5	1	0	3	1	0	2	0	1	1	0	0	1	15	1.2	11%
Older Residential	6	7	7	8	4	8	11	2	3	2	2	2	2	64	4.9	47%
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0%
Total	12	12	12	18	9	20	17	4	5	8	7	6	5	135	10.4	100%

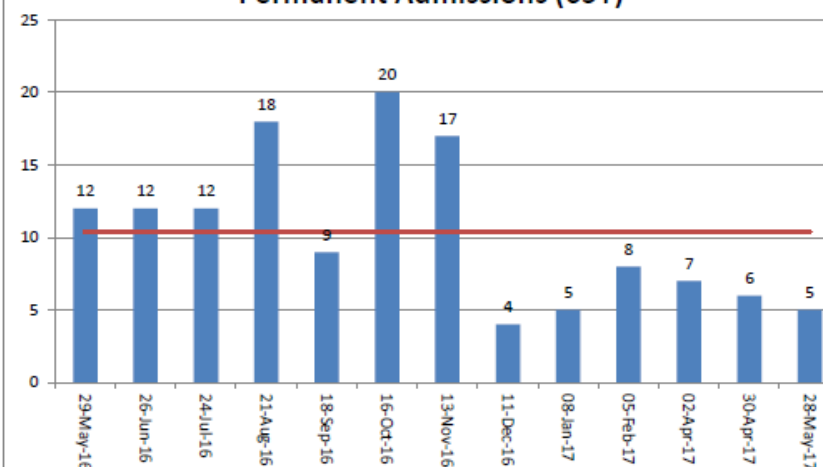
Permanent Admissions in Period by Type of Stay (65+):

Permanent admissions exclude transfers from one home to another (whether in borough or not), up or down grading of service from residential to nursing or vice versa, self funders or full cost admissions (client assessed as paying the full cost of care themselves). When a full cost client falls below the threshold of full cost (i.e. we would begin to make a financial contribution to their care) then they would become a permanent admission. A client in residential, who goes into hospital for a period resulting in HBC not paying for the placement, would count as additional permanent admission.

For the first seven months of the year there was an average of 14.3 permanent admissions per 4 week period while from Dec-16 to May-17 the average dropped to only 5.8. The overall average across the last year was 10.4.

This is the source data for the ASCOF PI 2A part 2 (older people).

Permanent Admissions (65+)



Data Source: All data above, both people in placement, as well as starts/admissions, is obtained from Hartlepool Adult Social Care's Controcc system – all data extracted by MIT. Updated 12-Jun-2017

APPENDIX 2: REABLEMENT ANALYSIS

1. Reablement Goals set & achieved

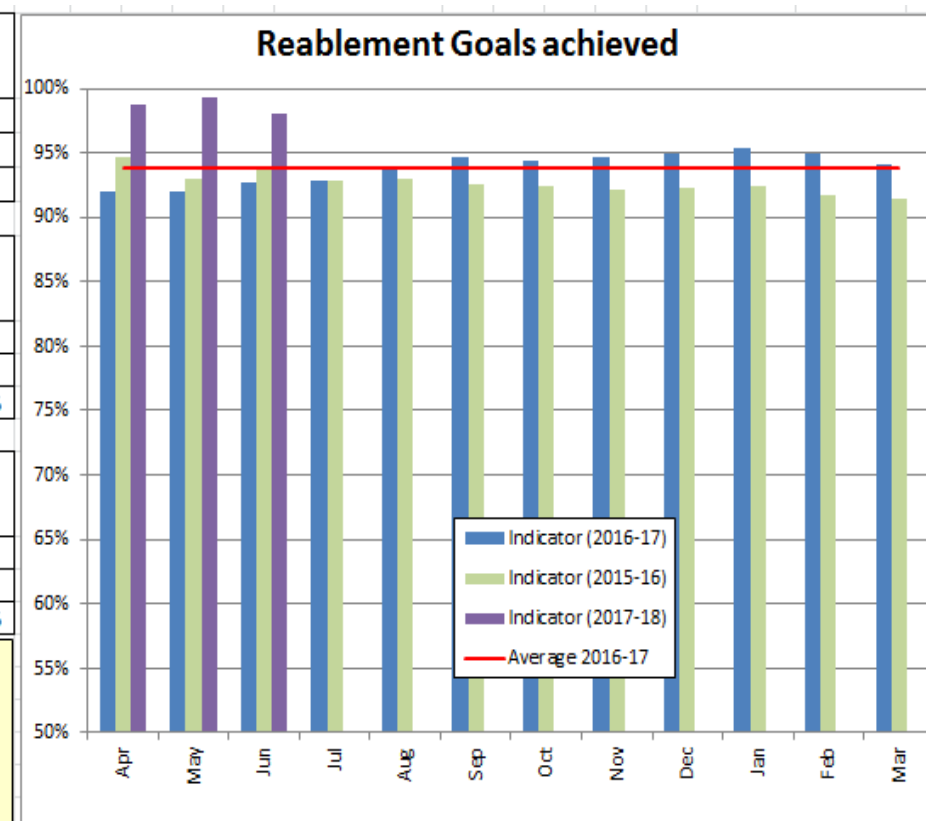
2017-18 Goals achieved	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Goals Achieved	80	136	200										0
Goals Set	81	137	204										0
Indicator (2017-18)	98.8%	99.3%	98.0%	-	-	-	-	-	-	-	-	-	-

2016-17 Goals achieved	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Goals Achieved	57	160	230	272	333	409	442	491	559	618	680	786	66
Goals Set	62	174	248	293	355	432	468	519	589	648	716	835	70
Indicator (2016-17)	91.9%	92.0%	92.7%	92.8%	93.8%	94.7%	94.4%	94.6%	94.9%	95.4%	95.0%	94.1%	94%

2015-16 Goals achieved	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
Goals Achieved	72	158	219	259	329	376	454	515	578	623	690	751	63
Goals Set	76	170	233	279	354	406	491	559	626	674	752	821	68
Indicator (2015-16)	94.7%	92.9%	94.0%	92.8%	92.9%	92.6%	92.5%	92.1%	92.3%	92.4%	91.8%	91.5%	91%

Reablement Goals:

This is based on a cumulative figure. The % of reablement goals achieved over the last 2 years has remained consistently high at approx 93-94%, with a slight increase in 2016-17 to a yearly average of 94%. This has also been consistent from month to month within each year, i.e. there are very few peaks and troughs of performance within the year, although Sep hit 99%, while Jan had 100% of Goals met. In 2016-17, all months with the exception of March 2017, were over 90%. This has now been updated with data for the first 3 months of 2017-18.



2. Reablement - % of people who have NO ongoing social care needs following provision of a completed reablement package

2017-18 No ongoing care needs	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
No Ongoing Services	31	49	81										0
Packages Completed	51	92	133										0
Indicator (2017-18)	60.8%	53.3%	60.9%	-	-	-	-	-	-	-	-	-	-

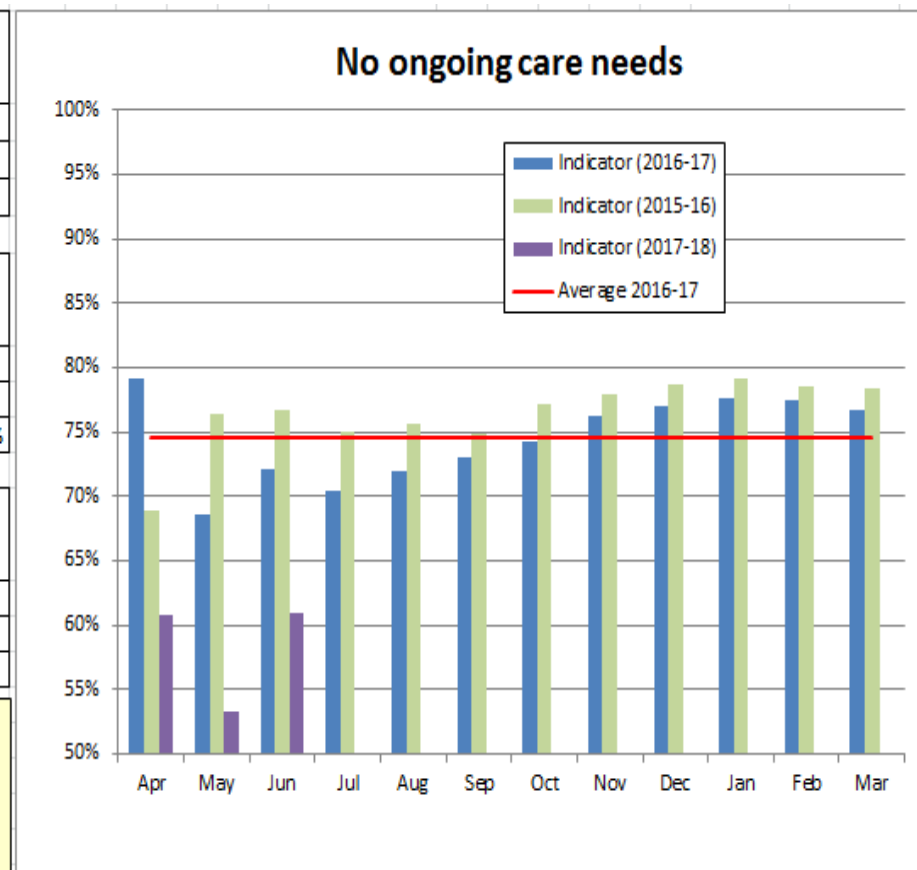
2016-17 No ongoing care needs	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
No Ongoing Services	34	70	93	112	146	184	207	240	272	302	331	370	31
Packages Completed	43	102	129	159	203	252	279	315	353	389	427	482	40
Indicator (2016-17)	79.1%	68.6%	72.1%	70.4%	71.9%	73.0%	74.2%	76.2%	77.1%	77.6%	77.5%	76.8%	76.8%

2015-16 No ongoing care needs	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
No Ongoing Services	31	71	99	123	158	181	219	254	288	312	339	371	31
Packages Completed	45	93	129	164	209	242	284	326	366	394	432	473	39
Indicator (2015-16)	68.9%	76.3%	76.7%	75.0%	75.6%	74.8%	77.1%	77.9%	78.7%	79.2%	78.5%	78.4%	78%

Reablement -No ongoing care needs :

This is based on a cumulative figure. Average for 2015-16 was 78%, with a slight drop to 77% in 2016-17. Performance in 2016-17 has continued to improve across the year, after lower levels of performance in a couple of months, i.e. May, July and March, but has resulted in a very similar level to 2015-16.

This has now been updated with data for the first 3 months of 2017-18.



All data above is obtained from Hartlepool Adult Social Care's CareFirst system - all data extracted by MIT
Updated 12-Jul-2017

APPENDIX 3: DELAYED TRANSFERS OF CARE ANALYSIS

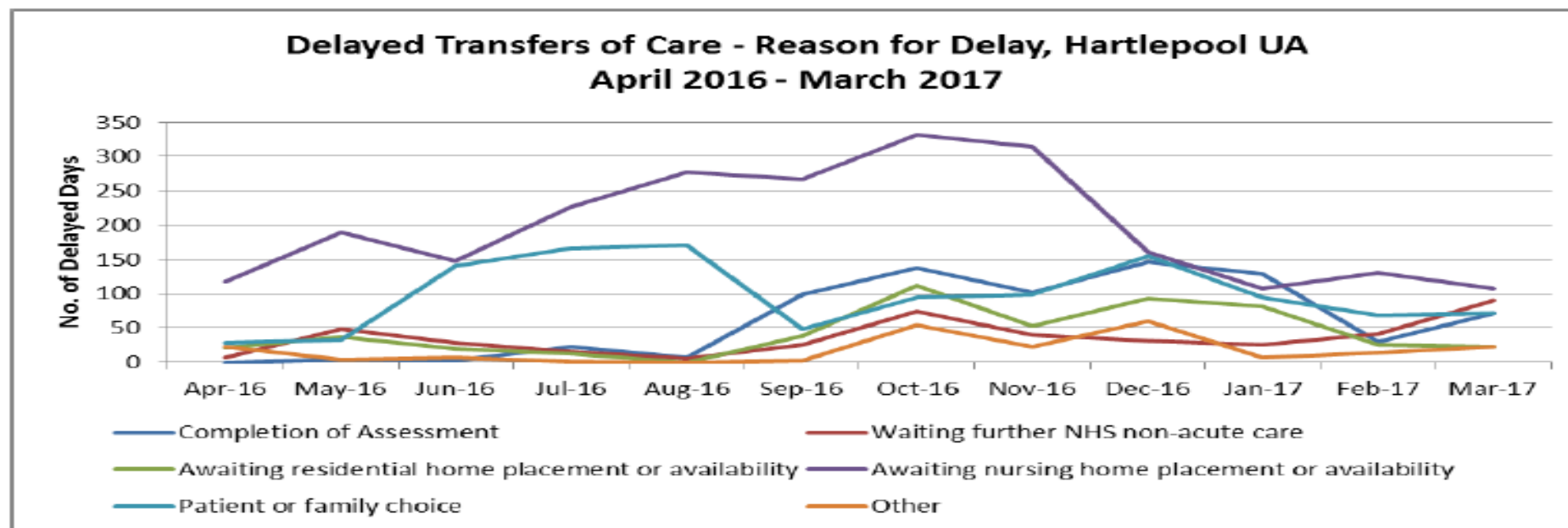
- There were 1,138 delayed days reported in Q4 2016/17, a decrease of 942 days from the previous quarter. Over the quarter, 993 delayed days were reported as being the responsibility of the NHS, and 145 days were reported as the responsibility of social care.
- Delays due to awaiting **nursing home placement/availability** decreased from 806 days in Q3 to 345 days in Q4.
- Over the year 2016/17 there were 5,458 delayed days reported, an increase of 3,143 (+136%) from the previous year. The main increases included **completion of assessment** (749 days compared to 79 in 2015/16), awaiting **nursing home placement/availability** (2,377 days compared to 1,060 in 2015/16) and **patient or family choice** (1,170 days compared to 558 in 2015/16).

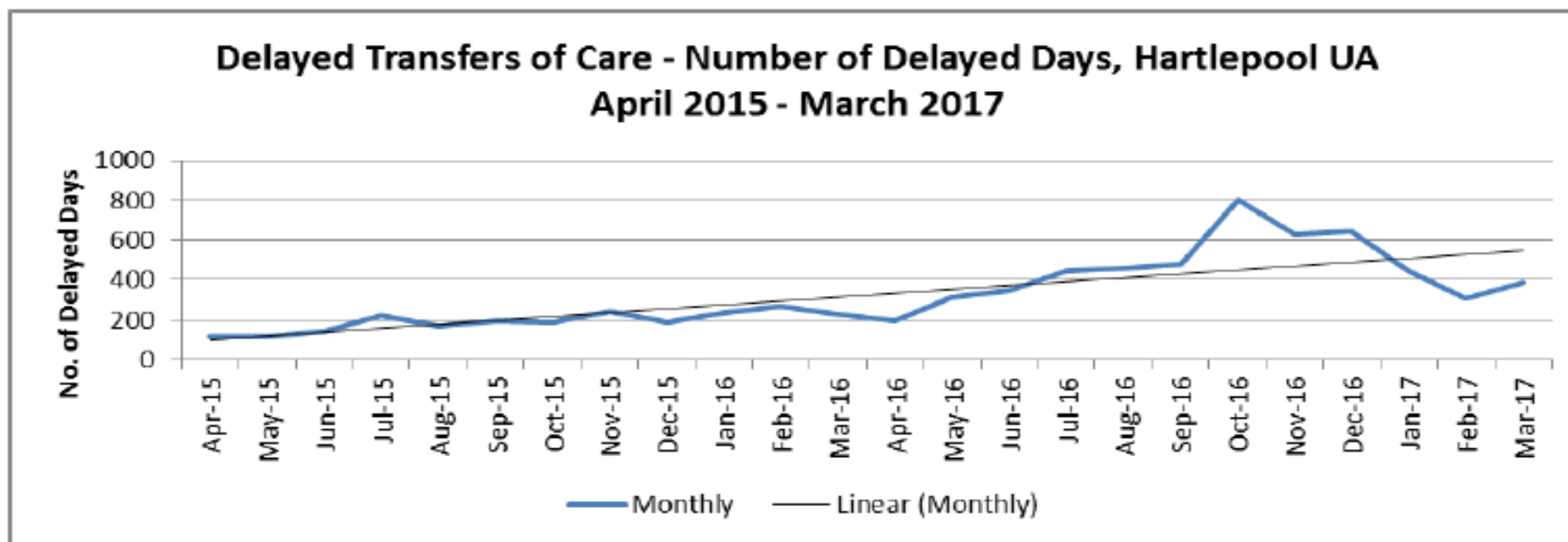
Delayed Transfer of Care - Number of Delayed Days during the reporting period - Hartlepool UA

Responsible Organisation	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
NHS	197	315	344	416	421	218	436	293	475	356	273	364	4,108
Social Care			2	28	38	261	363	325	170	87	35	23	1,332
Both							5	13					18
Total	197	315	346	444	459	479	804	631	645	443	308	387	5,458

Delayed Transfer of Care – Reason for Delay and number of Delayed Days during the reporting period – Hartlepool UA

Reason for delay	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total	%
Completion of Assessment		4	3	22	6	98	138	102	146	129	29	72	749	14%
Public Funding							5		37		1		43	1%
Waiting further NHS non-acute care	7	48	28	15	5	25	74	40	31	25	41	90	429	8%
Awaiting residential home placement or availability	21	37	20	13		38	111	53	93	82	26	23	517	9%
Awaiting nursing home placement or availability	118	189	148	227	277	267	332	314	160	107	130	108	2,377	44%
Awaiting care package in own home	17	3	2	1		3	35	15	12	5	2	12	107	2%
Awaiting community equipment and adaptations		1	4				2	8	4	1	11	5	36	1%
Patient or family choice	28	33	141	166	171	48	95	99	155	94	68	72	1,170	0%
Disputes							12		7				19	0%
Housing - patients not covered by NHS and Community Care Act	6											5	11	0%
Total	197	315	346	444	459	479	804	631	645	443	308	387	5,458	100%





Variance Apr-Mar 2016/17 compared to the same period of 2015/16

Delayed transfers of care from hospital per 100,000 population (18+)		2015/16 YTD*	2016/17 YTD	Variance	% Variance
Hartlepool LA	Numerator	2315	5458	+3143	+135.8%

% Variance to same period of previous year (numerator) is highlighted red if the numerator is higher than the same period of previous year, and green if lower.

APPENDIX 4: DELAYED TRANSFERS OF CARE UPDATE

The North Tees and Hartlepool Foundation Trust are implementing new initiatives and ways of working with the local authorities and it is anticipated that these will impact on the number of Delayed Transfers of Care.

These include:

- More daily open discussions amongst clinicians around DToC resulting in required actions earlier from all parties and implementation of patient choice policy.
- The Trust has had Social Care Officers on site since January 2017 working with Discharge Liaison team in the Hospital based at North Tees.
- The Trust implemented a nurse /therapy led unit as part of the winter resilience ward, working towards timely discharges.
- The Patient Choice policy is starting to embed in the Trust with all stakeholders involved in the process.
- The Trust is training ward staff to support timely discharge with a number of associate practitioners working with DLT increasing patient flow across the hospital.
- There was an increase in the number of patients placed out of area therefore the Trust has seen a reduction in the number of patients who have been waiting for nursing care within Hartlepool.

APPENDIX 5: – Hartlepool NON ELECTIVE Analysis

Admissions by Age Band

The table below shows activity and cost of NEL admissions by broad age bands, for the period April 2015-March 2016 and April 2016-March 2017.

NEL admissions 2015/16 and 2016/17

	Activity				Cost			
	2015/16	2016/17	No. Change	% Change	2015/16	2016/17	No. Change	% Change
0 to 19 yrs	1,976	2,256	280	14.2%	£1,614,985	£1,830,244	£215,259	13.3%
20 to 64 yrs	4,798	5,606	808	16.8%	£6,458,829	£7,751,605	£1,292,775	20.0%
65+ yrs	4,825	5,201	376	7.8%	£11,671,648	£12,660,710	£989,061	8.5%
Total	11,599	13,063	1,464	12.6%	£19,745,463	£22,242,558	£2,497,095	12.6%

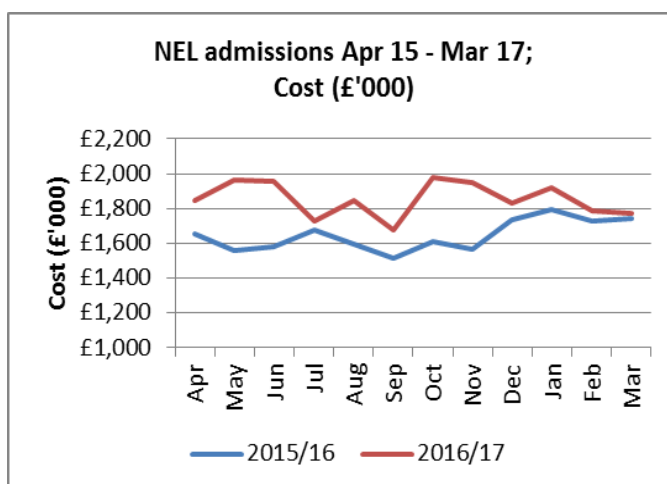
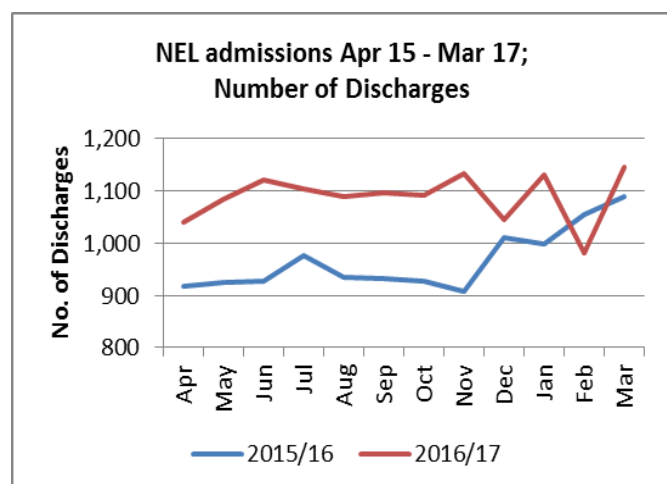
On comparison of the complete years 2015/16 and 2016/17, there was an **overall increase** of 12.6% for both admissions (+1,464 admissions) and cost (+£2,497,095).

For patients aged **0-19 years** there was an increase of 280 admissions (+14.2%) and £215,259 (+13.3%).

For patients aged **20-64 years** there was an increase of 808 admissions (+16.8%) and £1,292,775 (+20.0%).

For patients aged **65+ years** there was an increase of 376 admissions (+7.8%) and £989,061 (+8.5%).

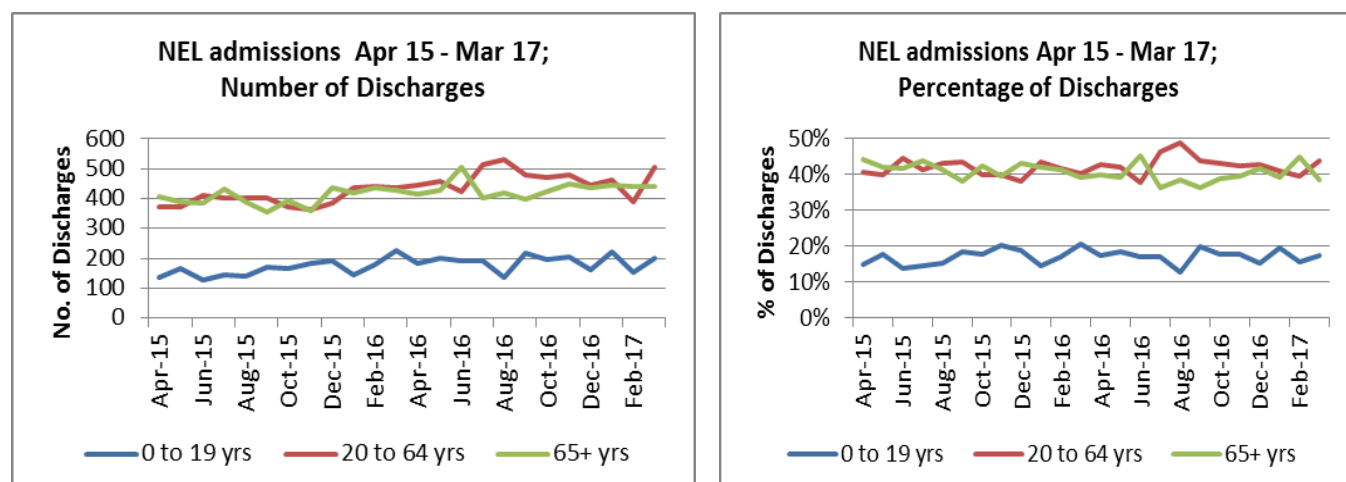
The charts below show the trends of the total number and cost of NEL admissions from April 2015 to March 2017.



In all months of 2016/17 (except February) the number of discharges was higher than in each month of the previous year.

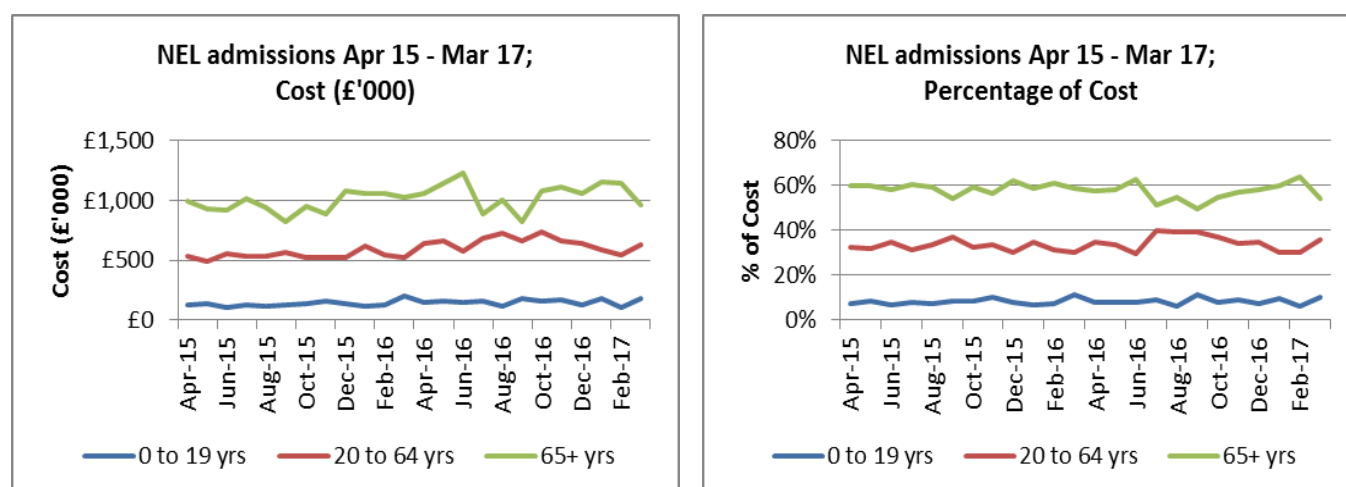
In all months of 2016/17 the cost of discharges was higher than in each month of the previous year. Some of this increase would have been due to the annual increase in HRG costs. In some months the cost appears to be lower than expected (when compared to the number of discharges); further analysis would be required to determine the reasons for this difference.

The charts below show admissions from April 2015 to March 2017 by broad age band.



Over the period April 2015 to March 2017 there were slight increases in the number of NEL admissions for patients aged 0-19 years and 65+ years, and a more significant increase in admissions for patients aged 20-64 years, particularly in July and August 2016.

The proportion of admissions for patients aged 20-64 years and 65+ years has remained at around 40% during this period, with a slightly higher proportion of admissions for patients aged 20-64 years in most months. Over the 2-year period, there was a slight downward trend for admissions for patients aged 65+ years.



The actual cost and proportion of cost for patients aged **0-19 years** remained steady throughout the last 2 years.

The monthly average cost of admissions for patients aged **20-64 years** was £538,000 in 2015/16, but increased to £646,000 in 2016/17 (an increase of 20%).

The monthly average cost of admissions for patients aged **65+ years** was £973,000 in 2015/16, but increased to £1,055,000 in 2016/17 (an increase of 8.5%).

For patients aged 20-64 years costs peaked at over £700,000 in August and October 2016, whilst for patients aged 65+ years July and September 2016 saw the lowest costs of the financial year.

Admissions by HRG – 65+ years

The tables below show the number and cost of non-elective admissions for patients aged 65+ years in the complete years 2015/16 and 2016/17, by HRG chapter. Please note that activity recorded locally as ambulatory care is referred to as HRG chapter AM – Ambulatory Care throughout this report.

NEL admissions 2015/16 and 2016/17, 65+ years, by HRG chapter

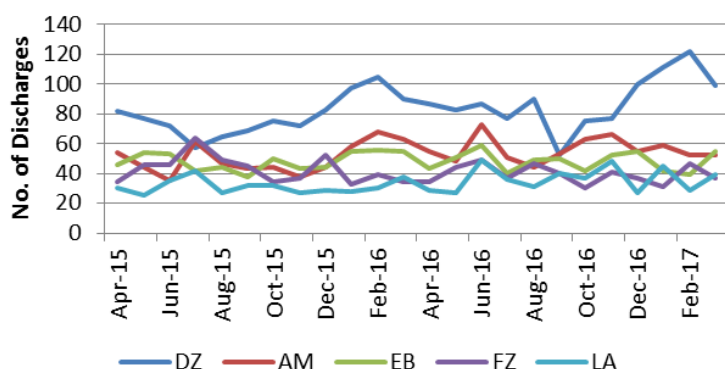
HRG Chapter	2015/16	2016/17	No. Change	% Change
DZ - Thoracic Procedures and Disorders	944	1,060	116	12.3%
AM - Ambulatory Care	599	671	72	12.0%
EB - Cardiac Disorders	580	577	-3	-0.5%
FZ - Digestive System Procedures	513	474	-39	-7.6%
LA - Renal Procedures and Disorders	375	437	62	16.5%
AA - Nervous System Procedures and Disorders	248	289	41	16.5%
HA - Orthopaedic Trauma Procedures	252	220	-32	-12.7%
Other	1,314	1,473	159	12.1%
Total	4,825	5,201	376	7.8%

Cost of NEL admissions 2015/16 and 2016/17, 65+ years, by HRG chapter

HRG Chapter	2015/16	2016/17	No. Change	% Change
DZ - Thoracic Procedures and Disorders	£2,495,277	£2,845,190	£349,913	14.0%
AM - Ambulatory Care	£278,259	£303,408	£25,148	9.0%
EB - Cardiac Disorders	£975,125	£881,733	£-93,391	-9.6%
FZ - Digestive System Procedures	£1,367,784	£1,226,153	£-141,631	-10.4%
LA - Renal Procedures and Disorders	£1,186,660	£1,441,461	£254,801	21.5%
AA - Nervous System Procedures and Disorders	£669,005	£818,115	£149,110	22.3%
HA - Orthopaedic Trauma Procedures	£1,006,615	£937,419	£-69,196	-6.9%
Other	£3,692,923	£4,207,231	£514,307	13.9%
Total	£11,671,648	£12,660,710	£989,061	8.5%

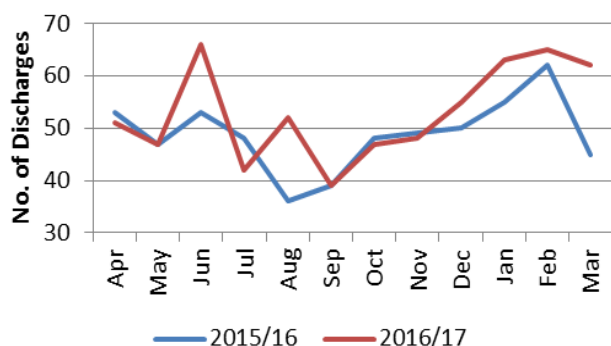
During 2016/17 the HRG chapters with the highest numbers of admissions were **DZ - Thoracic Procedures and Disorders** (mainly pneumonia, COPD or Unspecified Acute Lower Respiratory Infection) and **AM – Ambulatory Care**. The HRG chapter with the largest percentage increase in cost between 2015/16 and 2016/17 was **AA – Nervous System Procedures and Disorders**. Within this chapter, most activity had the primary diagnosis **I639 - Cerebral infarction, unspecified**.

NEL admissions Apr 15 - Mar 17;
top 5 HRG chapters, 65+yrs

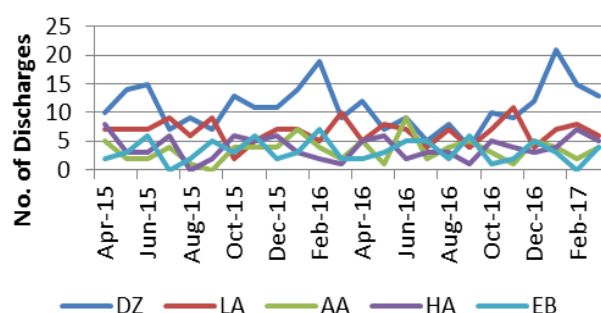


The winter increase in admissions for **DZ - Thoracic Procedures and Disorders** peaked in February in both years, with 105 admissions in February 2016 and 122 admissions in February 2017.

NEL admissions Apr 15 - Mar 17;
Admissions from Care Homes, 65+yrs



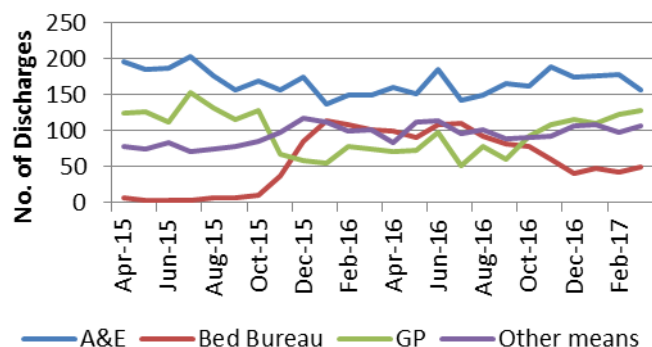
NEL admissions Apr 15 - Mar 17;
top 5 HRG chapters, Admissions from Care
Homes, 65+yrs



There was little change in admissions from care homes in the period April-December 2016 compared to the previous year.

The main HRG chapters for admissions from care homes were **DZ - Thoracic Procedures and Disorders** (mainly pneumonia, COPD or Unspecified Acute Lower Respiratory Infection) and **LA - Renal Procedures and Disorders** (mainly urinary tract infections).

NEL admissions Apr 15 - Mar 17
by admission type, 65+yrs



There was a significant increase in activity admitted via **Bed Bureau** from November 2015, and a corresponding decrease in admissions via **GP** from November 2015.

This was to be due a change in recording practice at North Tees and Hartlepool NHS FT which was rectified from October 2016.

HRG chapter DZ - Thoracic Procedures and Disorders

The table below gives details of non-elective admissions for the main HRG codes within this chapter, comparing activity and cost in 2015/16 and 2016/17.

NEL admissions 2015/16 and 2016/17, 65+ years: DZ - Thoracic Procedures and Disorders by HRG

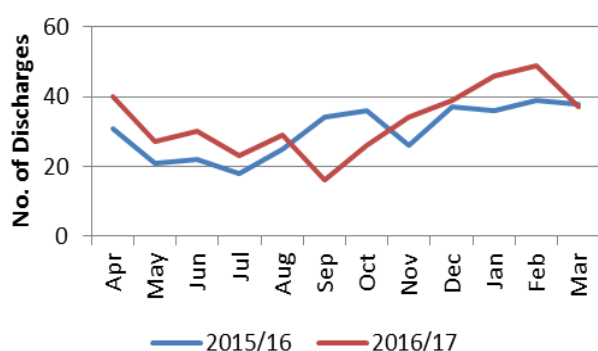
HRG	Activity				Cost			
	2015/16	2016/17	No. Change	% Change	2015/16	2016/17	No. Change	% Change
DZ11* - Lobar, Atypical or Viral Pneumonia	363	396	33	9.1%	£1,103,684	£1,231,842	£128,158	11.6%
DZ21* - COPD or Bronchitis	276	313	37	13.4%	£611,706	£673,294	£61,588	10.1%
DZ22* - Unspecified Acute Lower Resp Infection	114	119	5	4.4%	£281,889	£316,614	£34,725	12.3%
Other	191	232	41	21.5%	£497,998	£623,440	£125,442	25.2%
Total	944	1,060	116	12.3%	£2,495,277	£2,845,190	£349,913	14.0%

On comparison of the years 2015/16 and 2016/17, the main **increases** in activity and cost were for admissions for **DZ11* - Lobar, Atypical or Viral Pneumonia** and **DZ21* - COPD or Bronchitis**. Admissions for all these conditions were higher in most months of 2016/17 compared to 2015/16.

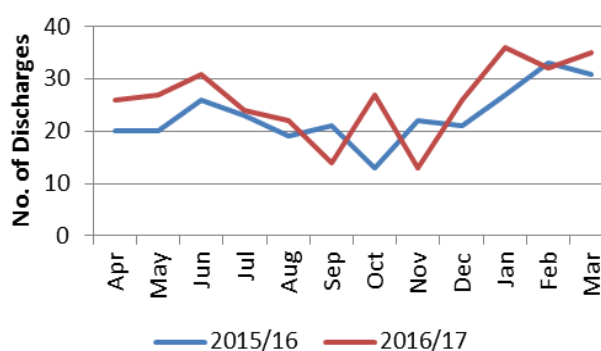
For admissions for **DZ22* - Unspecified Acute Lower Respiratory Infections**, the increase in cost is greater than the increase in activity due to a small number of patients with length of stay of 100+ days.

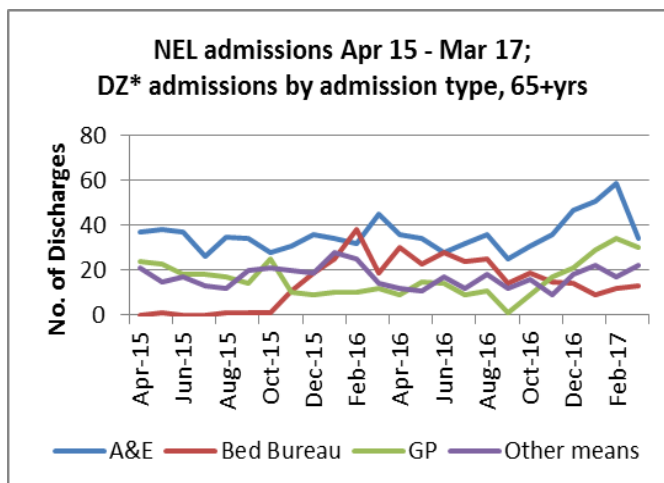
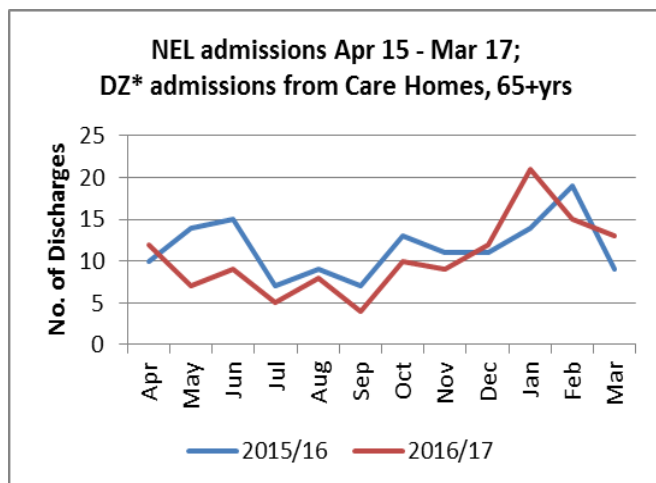
Admissions from **care homes** were lower in most months of 2016/17 compared to 2015/16.

NEL admissions Apr 15 - Mar 17; DZ11*
Lobar, Atypical or Viral Pneumonia, 65+yrs



NEL admissions Apr 15 - Mar 17;
DZ21* COPD or Bronchitis, 65+yrs





HRG chapter AMB – Ambulatory Care

Non-elective admissions classified as “Ambulatory Care” all have a length of stay (LoS) of 0 days.

The table below gives details of non-elective admissions for the main primary diagnoses within this chapter, comparing activity and cost in 2015/16 and 2016/17.

NEL admissions 2015/16 and 2016/17, 65+ years: AM - Ambulatory Care by Primary Diagnosis

Primary Diagnosis	Activity				Cost			
	2015/16	2016/17	No. Change	% Change	2015/16	2016/17	No. Change	% Change
M798 - Other specified soft tissue disorders	36	53	17	47.2%	£10,213	£15,202	£4,988	48.8%
R074 - Chest pain, unspecified	35	38	3	8.6%	£27,962	£30,693	£2,731	9.8%
R073 - Other chest pain	27	37	10	37.0%	£21,571	£29,885	£8,314	38.5%
I209 - Angina pectoris, unspecified	30	27	-3	-10.0%	£23,967	£21,808	£-2,159	-9.0%
L031 - Cellulitis of other parts of limb	21	24	3	14.3%	£11,110	£12,093	£983	8.8%
Other	450	492	42	9.3%	£183,436	£193,727	£10,292	5.6%
Total	599	671	72	12.0%	£278,259	£303,408	£25,148	9.0%

On comparison of the years 2015/16 and 2016/17, the main **increases** in activity and cost were for admissions with primary diagnoses **M798 – Other specified soft tissue disorders** and **R073 – Other chest pain**.

HRG chapter EB – Cardiac Disorders

The tables below give details of non-elective admissions for the main HRGs for admissions for cardiac disorders, comparing activity and cost in 2015/16 and 2016/17.

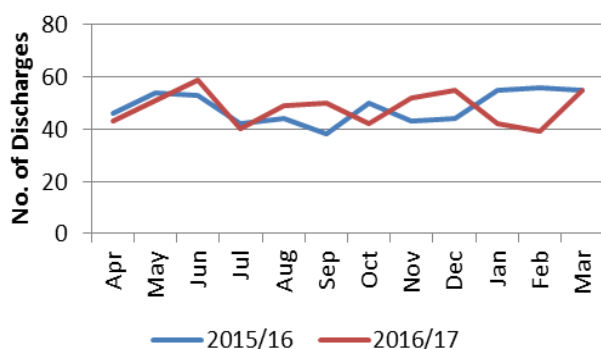
NEL admissions 2015/16 and 2016/17, 65+ years: EB - Cardiac Disorders by HRG

HRG	Activity				Cost			
	2015/16	2016/17	No. Change	% Change	2015/16	2016/17	No. Change	% Change
EB01Z - Non-Interventional Acquired Cardiac Conditions	153	180	27	17.6%	£116,412	£113,124	£-3,287	-2.8%
EB03H - Heart Failure or Shock with CC	87	84	-3	-3.4%	£296,931	£279,383	£-17,548	-5.9%
EB10Z - Actual or Suspected Myocardial Infarction	70	70	0	0.0%	£214,522	£190,058	£-24,464	-11.4%
EB07I - Arrhythmia or Conduction Disorders without CC	72	64	-8	-11.1%	£53,553	£51,983	£-1,570	-2.9%
EB08H - Syncope or Collapse with CC	61	50	-11	-18.0%	£86,182	£61,492	£-24,690	-28.6%
Other	137	129	-8	-5.8%	£207,525	£185,692	£-21,832	-10.5%
Total	580	577	-3	-0.5%	£975,125	£881,733	£-93,391	-9.6%

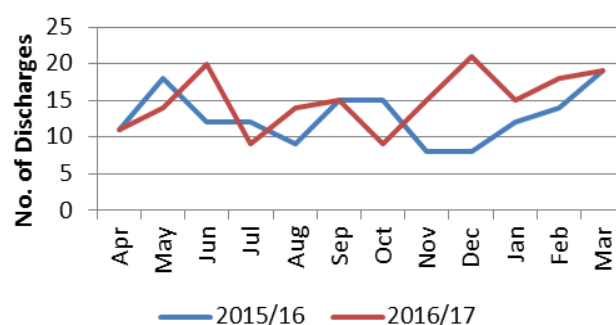
On comparison of the years 2015/16 and 2016/17, there was an **increase** in activity for **EB01Z – Non-Interventional Acquired Cardiac Conditions**, but a **decrease** in cost. The **increase in activity** was largely due to an increase in admissions with primary diagnosis **R07* - precordial/chest pain** (from 70 admissions in 2015/16 to 102 admissions in 2016/17); most of these admissions resulted in a length of stay (LoS) of 0-1 days and therefore low cost. The **decrease in cost** was due to lower numbers of admissions resulting in **long LoS**. For admissions costing >£1,000, in 2015/16 there were 15 admissions, with a total of 251 beddays and cost of £44,240; in 2016/17 there were 11 admissions with a total of 164 beddays and cost of £27,019.

There was **no change** in activity for **EB10Z – Acute or Suspected Myocardial Infarction**, but a **decrease** of 11.4% in cost. This was largely due to a small number of patients in 2015/16 with LoS of 60+ days costing >£10,000 each.

EB* Cardiac Disorders, 65+yrs



EB01Z - Non-Interventional Acquired Cardiac Conditions, 65+yrs



There has been little variation in overall activity for cardiac disorders from April 2015, with the number of monthly admissions being between 40 and 59. The increase in activity for **EB01Z – Non-Interventional Acquired Cardiac Conditions** was mainly for admissions with primary diagnosis **R07* - precordial/chest pain**.

HRG chapter FZ – Digestive System Procedures and Disorders

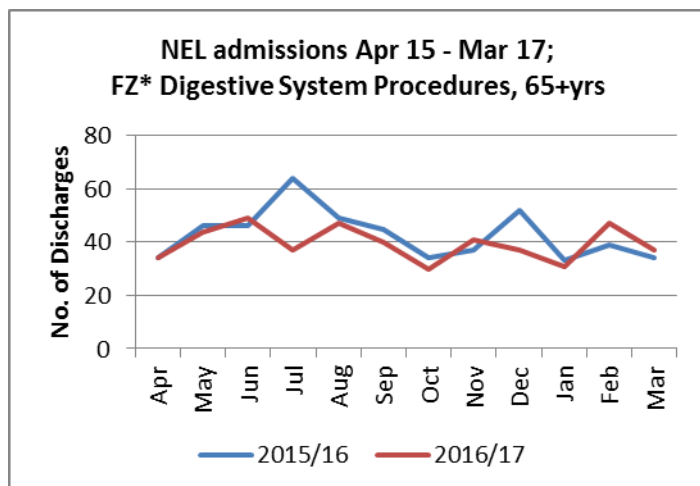
The table below gives details of non-elective admissions for the main primary diagnoses for admissions for digestive system procedures and disorders, comparing activity in 2015/16 and 2016/17.

NEL admissions 2015/16 and 2016/17, 65+ years: FZ - Digestive System Procedures and Disorders by Primary Diagnosis

Primary Diagnosis	Activity				Cost			
	2015/16	2016/17	No. Change	% Change	2015/16	2016/17	No. Change	% Change
K590 - Constipation	59	56	-3	-5.1%	£113,818	£95,783	£-18,035	-15.8%
A099 - Gastroenteritis and colitis of unspecified origin	51	24	-27	-52.9%	£116,702	£58,944	£-57,758	-49.5%
K922 - Gastrointestinal haemorrhage, unspecified	28	38	10	35.7%	£59,675	£86,826	£27,151	45.5%
R104 - Other and unspecified abdominal pain	26	19	-7	-26.9%	£26,705	£18,009	£-8,696	-32.6%
Other	349	337	-12	-3.4%	£1,050,884	£966,591	£-84,293	-8.0%
Total	513	474	-39	-7.6%	£1,367,784	£1,226,153	£-141,631	-10.4%

There was an overall **decrease** in admissions for digestive system procedures and disorders between 2015/16 and 2016/17.

The largest decrease was for admissions with primary diagnosis **A099 – Gastroenteritis and**



HRG chapter LA – Renal Procedures and Disorders

The tables below give details of non-elective admissions for the main primary diagnoses and HRGs for admissions for renal procedures and disorders, comparing activity in 2015/16 and 2016/17.

NEL admissions 2015/16 and 2016/17, 65+ years: LA - Renal Procedures and Disorders by Primary Diagnosis

Primary Diagnosis	Activity				Cost			
	2015/16	2016/17	No. Change	% Change	2015/16	2016/17	No. Change	% Change
N390 - Urinary tract infection, site not specified	289	330	41	14.2%	£933,236	£1,123,161	£189,925	20.4%
N179 - Acute renal failure, unspecified	56	76	20	35.7%	£181,669	£252,528	£70,859	39.0%
Other	30	31	1	3.3%	£71,756	£65,773	£5,983	-8.3%
Total	375	437	62	16.5%	£1,186,660	£1,441,461	£254,801	21.5%

NEL admissions 2015/16 and 2016/17, 65+ years: LA - Renal Procedures and Disorders by HRG

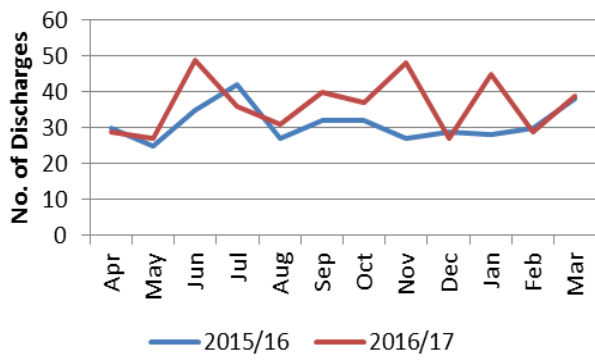
HRG	Activity				Cost			
	2015/16	2016/17	No. Change	% Change	2015/16	2016/17	No. Change	% Change
LA04D - Kidney or Urinary Tract Infections with length of stay 2 days or more with Major CC	180	238	58	32.2%	£753,667	£1,022,449	£268,781	35.7%
LA04E - Kidney or Urinary Tract Infections with length of stay 2 days or more with Intermediate CC	71	36	-35	-49.3%	£166,897	£74,650	£92,247	-55.3%
LA04G - Kidney or Urinary Tract Infections with length of stay 1 day or less	37	56	19	51.4%	£15,813	£24,201	£8,388	53.0%
Other	87	107	20	23.0%	£250,283	£320,162	£69,879	27.9%
Total	375	437	62	16.5%	£1,186,660	£1,441,461	£254,801	21.5%

The most common primary diagnosis within this chapter was **N390 - Urinary tract infection, site not specified**, and most admissions with this diagnosis were grouped into HRG codes **LA04* - Kidney or Urinary Tract Infections**.

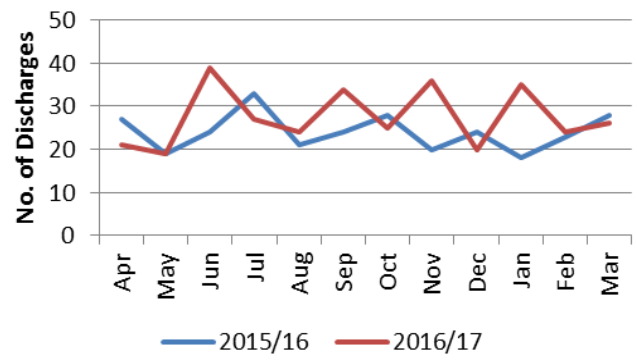
On comparison of the years 2015/16 and 2016/17, there was an **increase** in activity and cost for primary diagnosis **N390 - Urinary tract infection, site not specified**. Analysis of HRGs LA04* showed that there was an **increase** in admissions with **length of stay 1 day or less (LA04G)**, and for **admissions of 2+ days** where patients had **major CC (LA04D)**, but a **decrease** for **admissions of 2+ days** where patients had **intermediate CC (LA04E)**. This decrease may be due to earlier discharge of patients (and increase in LA04G), or may be because patients have (or are being coded as having) more co-morbidities and complications (increase in LA04D).

For primary diagnosis **N179 – Acute renal failure, unspecified**, there was a greater increase in cost compared to activity; this was mainly due to an increase in admissions to HRG **LA07D - Acute Kidney Injury with Major CC with Interventions**.

NEL admissions Apr 15 - Mar 17;
LA* - Renal Procedures and Disorders, 65+yrs



NEL admissions Apr 15 - Mar 17; N390 - Urinary
tract infection, site not specified, 65+yrs



APPENDIX 6: care home training programme



**NORTH TEES AND HARTLEPOOL
EDUCATION ALLIANCE**

Quarter 1 Report

February – April 2017

Karen Hampshire

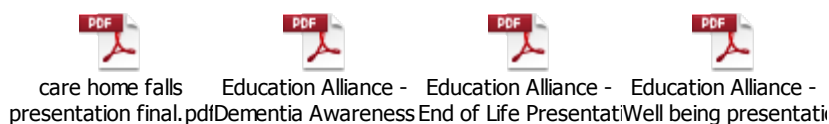
Clinical Educator – Education & Organisational Development, NTHFT

May 2017

Introduction

North Tees and Hartlepool Foundation Trust are co-ordinating an alliance of organisations known as North Tees and Hartlepool Education Alliance (NTHEA). This was developed from Better Care Fund (BCF) funding to support care homes by delivering a package of training for all the staff working within the care homes in Stockton and Hartlepool. NTHEA are delivering training on four topics; Dementia and Delirium, Falls Prevention (Stockton only), End of Life Care, and The Well-being of the Frail and Elderly Resident.

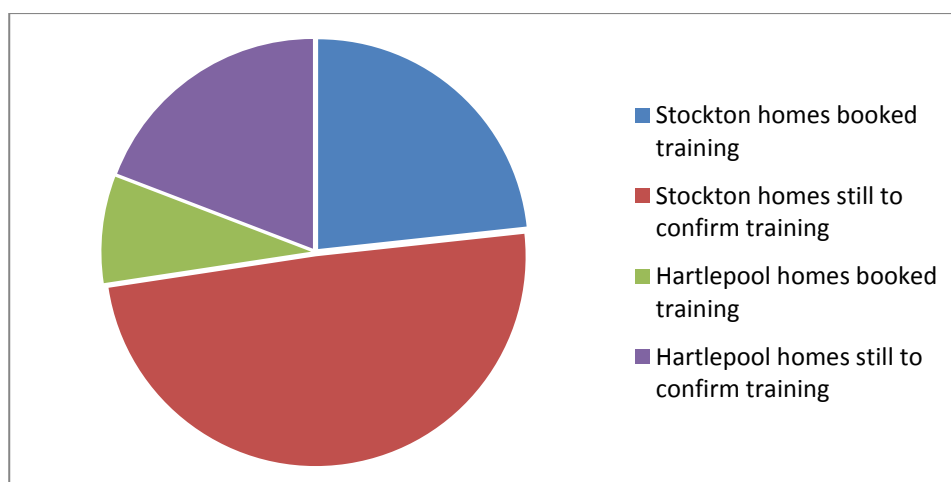
The training package comprises of 2 hour sessions for each of the 4 topics, being delivered within the care home setting. The training was developed in view of improving the quality of care within care homes. This includes the recognition of the deteriorating resident and increasing the knowledge and confidence of the staff when referring the resident to other services. This increased confidence will assist in retaining staff working in the care home. A further aim is to reduce avoidable admissions and readmissions to hospital, with topics including nutrition and hydration, prevention of UTI's and recognising when residents are becoming unwell and acting appropriately and in a timely manner. Also with the end of life training we aim to see a reduction in patients dying within 24 – 48 hours of admission to hospital at end of life.



The first session was delivered on 28th February 2017. All care homes that have been contacted (except Wynyard Woods) have agreed to the training and the booking process is on-going.

Progress

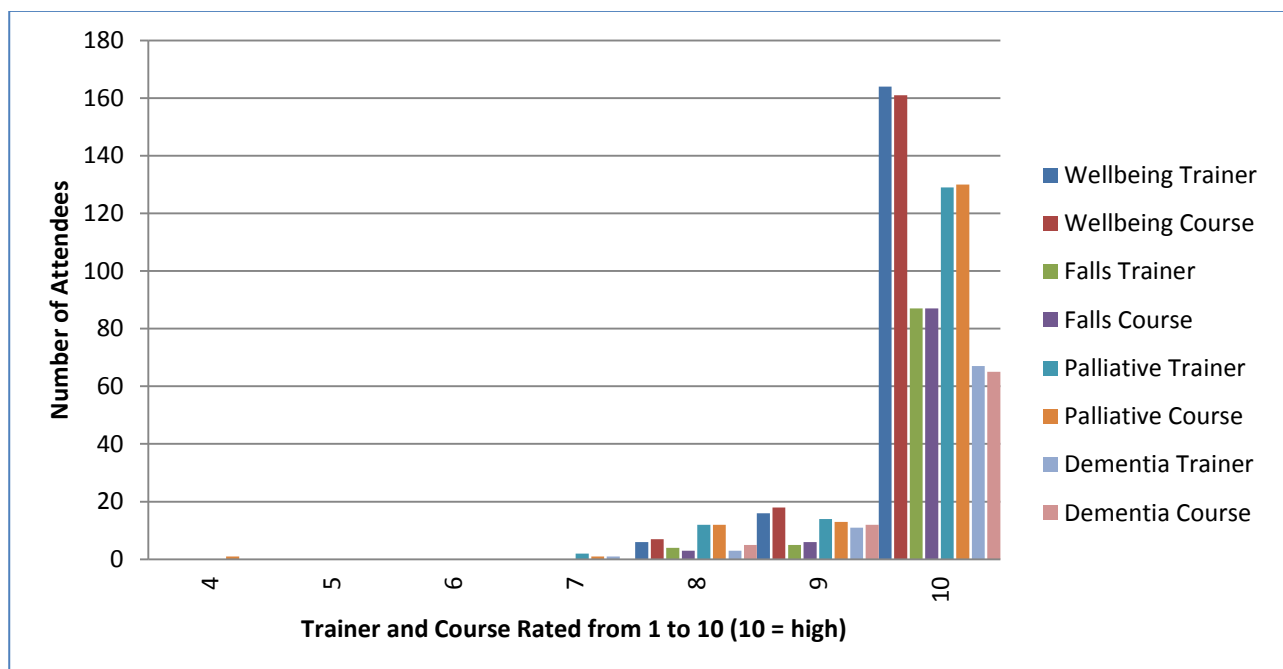
Presently 47% (17 out of 36) of homes in Stockton, and 43% (6 out of 14) of homes in Hartlepool have confirmed dates for training. Up to the end of April there are 6 homes that have completed all of the training topics.



As homes are both nursing and residential homes there is a mix of staff that attend the sessions which is a positive aspect, but the managers themselves have not been able to attend, therefore two training days have been arranged specifically for the managers where they will receive all four elements of the training. This will enable them to see the quality of the training and encourage them to book in training if they haven't done so already.

The staff are given Pre and Post session questionnaires, to assess whether they feel their understanding and confidence has increased. We have received 247 completed questionnaires and the feedback has been very positive with 100% stating it had increased.

Attendees asked to rate the trainers and the course



'Wellbeing of the Elderly'

"What would you like to learn from the training today?"

- "Different ways to promote wellbeing"
- "More knowledge of how I can contribute to health and wellbeing of the resident"
- "Different ways to promote wellbeing"
- "More knowledge of how I can contribute to the health and wellbeing of our residents"
- "What wellbeing means?"
- "Anything that can improve care to the elderly with complex needs due to varying conditions"

“What have you learned from the training today?”

- “The correct colour for urine and correct amount of fluids for weight of resident and nutritional information”
- “More ways to improve myself and help the residents improve their wellbeing eg the importance of fluid and diet”
- “To observe sores more frequently and note and report all changes to a senior member”
- “How to identify problems with skin sores. UTI’s and deterioration.

Falls Awareness

“What would you like to learn from training today?”

- “About falls, good practice for dealing with preventing falls”
- “How to act when there is a fall situation and what to do”
- “How to keep residents safe”
- “More prevention techniques”

“What have you learned from the training today?”

- “About what a fall is. The impact a fall can have. The care workers responsibility duty of care in preventing falls”.
- “How to support a resident if they have a fall and how to prevent next time to assist in prevention of falls and how to deal with falls if one occurs”
- “Medication that can cause falls”

Dementia and Delirium Awareness

“What would you like to learn from the training today?”

- “How to support residents with dementia”
- “How I can help provide a person centred approach”
- More information about recognising different dementias”
- Have more insight into dementia an delirium and how to support residents to be aware of services to support this”

“What have you learned from the training today?”

- “About dementia and different types and how to deal with it”
- “A little more on the Abbey Score, Maslows and the way a resident can have a trigger to challenging behaviour”
- “How to aid communication”
- “The different stages of dementia and how it progresses”

End of Life Care

“What would you like to learn from the training today?”

- “The best way to care for someone on end of life care”
- “More about palliative care”
- “Be more confident with residents at end of life”
- “More person centred to give my full attention to the person involved and to support their families”

“What have you learned from the training today?”

- “How to effectively care for someone on end of life”
- “To help and give more confidence in a very emotive matter of palliative care and death”
- “Recognising changes during the last days and weeks of someone’s life and how to support families”
- “How to be more communicative with staff and families”

Digital NEWS Pilot

National Early Warning Score (NEWS) awareness and the implementation of the digital NEWS technology have been successfully implemented by Sunderland CCG. Following their success, BCF funding is being used to fund the introduction of 38 devices across care homes in Stockton and Hartlepool.

Two pilot homes have been identified, both nursing homes, one of which is currently aware of NEWS therefore the transition to digital technology should be relatively straightforward. Allocation of the digital kits will depend on size of home and the number of residents they have. It will be based on approximately 1 kit per 30 residents or if the home’s layout is spread across several floors or areas it may be beneficial to provide more to allow staff to have easy access to the kit as needed.

Training will be arranged for each care home prior to introducing the digital kit. This is a 3 hour training session which includes; how NEWS works and its benefits, understanding the 6 physiological parameters included in NEWS, demonstrating correct use of NEWS and appropriate clinical response, correct use of the digital kit and accessing the Whzan website to retrieve residents’ observations.

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

Both pilot homes (Brierton Lodge in Hartlepool and Church View in Stockton) have received the consent documentation for residents to sign, ensuring there is proper

governance around the use of the data. Once this has been received training on the digital NEWS equipment will be delivered and data collection monitored while staff using the equipment to capture residents baseline scores.

Training sessions to commence the pilots have been scheduled with both homes during the second half of June and it is anticipated that following evaluation of the pilot nursing homes, two residential homes will be identified to receiving the digital equipment.

Issues / Challenges

Some issues that we have encountered include;

- following initial contact with the care home to book training, they are not always replying in a timely manner, which makes it difficult to coordinate the delivery team. However some homes are requesting to book more sessions following the success of the initial ones, but we plan to get around most of the homes at first then to rebook for the latter part of the year.
- Wellburn House – Dementia session cancelled due to trainer not turning up.
- Cedar Lodge – Wellbeing of the Elderly and End of Life Care sessions cancelled as manager informed staff of incorrect date of training
- Lindisfarne – End of Life Care session cancelled as manager on leave and staff not available for training (Dementia training did take place on a later session)
- Elwick Grange – Wellbeing of the Elderly and End of Life Care cancelled due to manager not aware of early Easter break in Hartlepool and staff not available.
- Hadrian House – Wellbeing of the Elderly and End of Life Care cancelled due to home having cases of Diarrhoea and Vomiting
- All homes have rearranged training for a later date.
- Attendance has been variable, ranging from 2- 38 (averaging out to 10 per session) and the main reason for non –attendance is being unable to release staff from their duties.

There have also been specific home issues that have been highlighted during sessions, and this has enabled us to open up discussions with staff and managers.

Two examples of areas where the training has highlighted that further training or support for staff is required has been the lack of knowledge and confidence for some staff when performing hygiene care for residents with catheters in particular male residents and ensuring the foreskin is retracted for cleaning if the resident is unable to do it himself. It was apparent that this is not being done everywhere by all staff therefore further discussion with staff and then the manager has enabled further support to be given to staff.

Also regarding a variation of types of food provided for the residents and staff stating concerns about the repetitiveness and quality of some food, and again this enabled me to take their concerns to the manager of the home.

Feedback

Overall the training is going very well with many positive comments returned on the evaluation questionnaires. Staff are asked what the highlights of the training were, some of the comments are listed below.

A large number staff attending the End of Life care felt that that discussing issues as a group with colleagues really helped. Comments received include:

- Discussing different experiences of palliative care
- Group discussions
- The discussions were good, having a free exchange of ideas. Good humoured
- That we were open to talk about things
- Understanding everyone's emotions and attachments and dealing with clients families.
- Listening to others.
- Hearing different opinions and stories

Comments from the Falls Awareness showed staff benefitting from trying on the weight suits and different impairment devices in an effort to gain insight on how elderly residents feel. Comments received include:

- Experience with equipment and resources
- How residents feel when walking and with body weight
- How to identify with how residents may physically feel
- How the residents feel and have understanding about different problems i.e. body weight etc.
- Using equipment to help you visualise sensory difficulties the elderly face on a daily basis
- Experiencing the heavy suit and how it felt and what it feels like to an elderly person

Staff attending the Dementia and Delirium Awareness sessions felt that understanding the different types of Dementia helped and understanding the differences between Dementia and Delirium. Comments received include:

- Different types of dementia
- The different stages of dementia
- Knowledge and more understanding of dementia
- More in depth knowledge of dementia
- Different dementias
- Delirium - I gathered more understanding about this
- The course has improved my training for everyday I go to work. Thank you

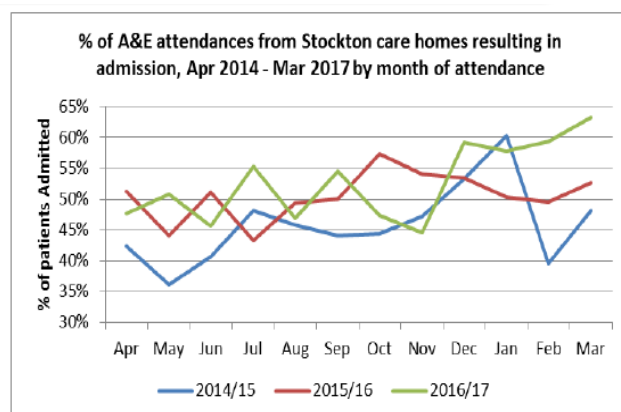
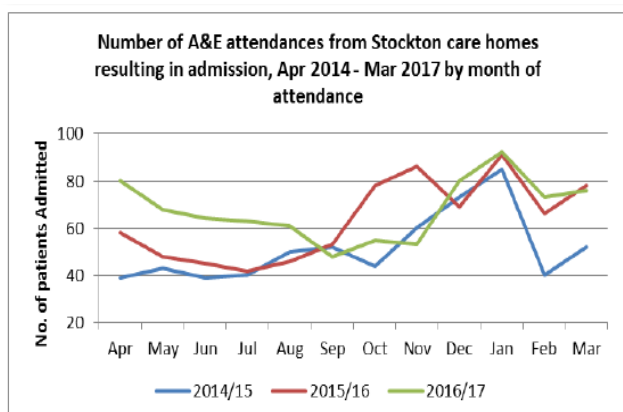
Comments from the Wellbeing of the Elderly showed staff appreciating the information given around Diet and Fluid intake and skin integrity. Comments received include:

- Importance of promoting wellbeing of residents, ensuring they are hydrated and nutrition.
- Hydration
- Identifying deterioration
- Skin integrity
- Nutrition and Hydration
- Symptoms of dehydration and malnutrition
- Food and fluid intake and skin breakdown
- Learning how much water a resident has to drink per day
- Skin awareness and making sure those residents catheters are checked and cleaned, also checking private areas.

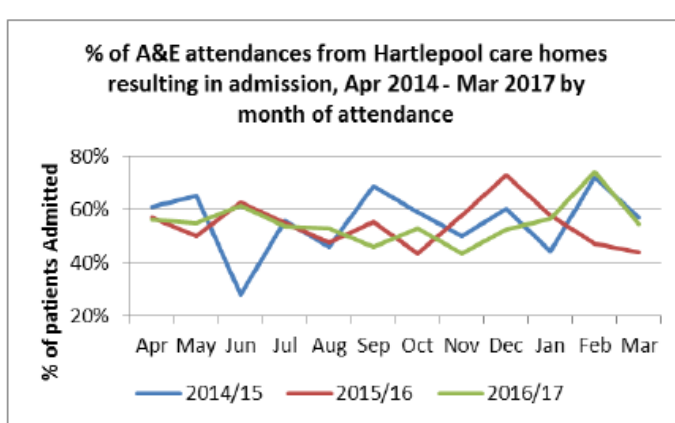
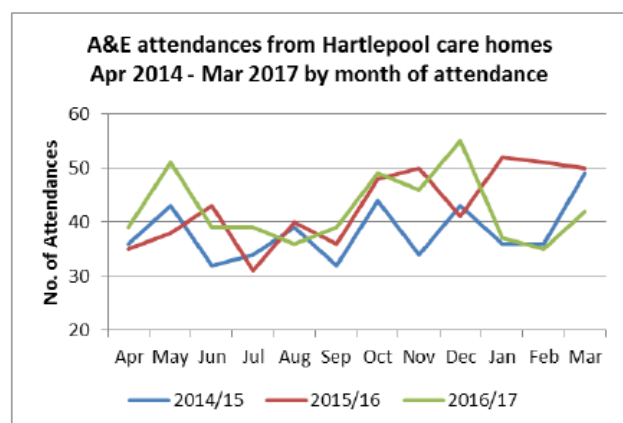
Impact of training on key indicators

Reduction in A&E Attendances

Stockton: monitored quarterly

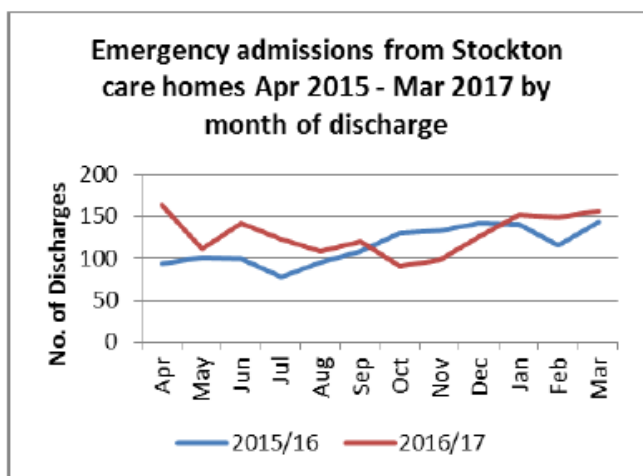


Hartlepool: monitored quarterly

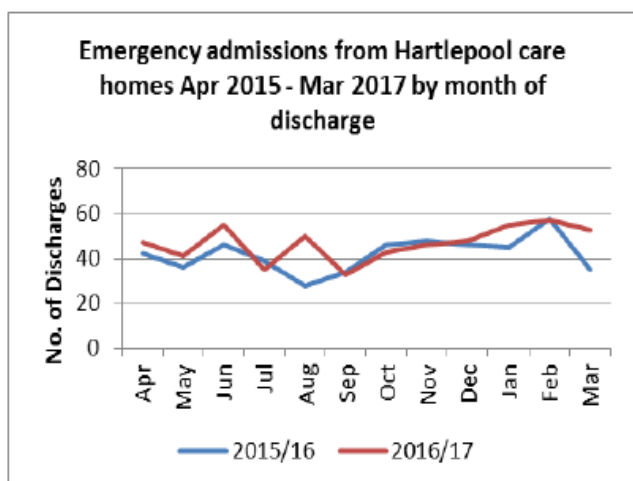


Reduction in Emergency Admissions

Stockton: monitored quarterly



Hartlepool: monitored quarterly



Reduction in Emergency Admissions from Care Homes which end with the patient dying broken down to within 0<24, 24-<48 and 48+ hours

	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Total	%
0- <24hrs	<6	<6	11	9	27	10.5%
24- <48hrs	7	<6	7	<6	23	9.0%
48+hrs	47	34	52	73	206	80.5%
Total	59	40	70	87	256	100.0%

Increased calls to SPA

	Provider Name: NTHFT		Sep-16		Oct-16	Nov-16	Dec-16		Jan-17	Feb-17	Mar-17	
		Measure		QTR 2				QTR 3				QTR 4
Contacts / Referrals into SPA	Residency Status of Individual - Residential Home	Actual	1350	1350	1294	1984	2088	5366	2136	2019	2075	6230
	Residency Status of individual - Nursing Home	Actual	71	71	456	657	664	1777	601	564	626	1791
	Total			1421				7143				8021
Clinical Triage	Residency Status of Individual - Residential Home	Actual	187	265	133	122	31	286	43	21	37	101
	Residency Status of individual - Nursing Home	Actual	11	20	10	0	0	10	2	15	8	25
Total				285				296				126

Local Quality Requirements Report – Q1

Quality Requirement	Threshold	Comments																																			
Pre/ Post questionnaire designed developed and sign-off prior to commencement of the Training and Education Programme. Questionnaire to cover the pre/ post training increase in knowledge, understanding and confidence, the quality of the training provided (subject, training material, delivery, trainer etc) and suggestions for improvement		See “Feedback” section above.																																			
All staff to have an increased understanding and confidence following the training	100%	247 evaluations received following training to date. 100% of respondents have noted an increased understanding and confidence following the training.																																			
All Care Homes identified as participating in the programme to have received all of the training sessions within 12 months of programme commencement	100%	All care homes contacted and have agreed to training. Ongoing process of booking dates for homes. To date 17 of the 36 homes in Stockton have confirmed training dates (47%) and 6 of the 14 homes in Hartlepool have confirmed training dates (43%) Up to end of April 2017, 6 care homes have completed training in all topics. The Poplars, Ingleby Care Home, Teesdale Lodge, Cedar Lodge, Cherry Tree and Woodside Grange																																			
NEWS: All homes identified to be trained and using the equipment within 12 months of programme commencement		Training in the use of NEWS has been rolled out to the Community Matrons and District Nursing team. Ongoing training organized for SPA team and Triage Nurses. Training for Brierton and Church View will be completed by June 2017. Both homes have consent forms for their residents and will be contacting Trust when completed.																																			
Reduction in A&E Attendances from Care Homes	Overall Reduction	In Q3 there were 370 attendances to A&E from Care homes. This will be used as the baseline for this report on wards.																																			
Reduction in Emergency Admissions from Care Homes	Overall Reduction																																				
Reduction in Emergency Admissions from Care Homes which end with the patient dying broken down to within 0<24, 24-<48 and 48+	5% reduction	<table><tr><th></th><th>Apr-Jun 16</th><th>Jul-Sep 16</th><th>Oct-Dec 16</th><th>Jan-Mar 17</th><th>Total</th><th>%</th></tr><tr><td>0-<24hrs</td><td><6</td><td><6</td><td>11</td><td>9</td><td>27</td><td>10.5%</td></tr><tr><td>24-<48hrs</td><td>7</td><td><6</td><td>7</td><td><6</td><td>23</td><td>9.0%</td></tr><tr><td>48+hrs</td><td>47</td><td>34</td><td>52</td><td>73</td><td>206</td><td>80.5%</td></tr><tr><td>Total</td><td>59</td><td>40</td><td>70</td><td>87</td><td>256</td><td>100.0%</td></tr></table>		Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Total	%	0-<24hrs	<6	<6	11	9	27	10.5%	24-<48hrs	7	<6	7	<6	23	9.0%	48+hrs	47	34	52	73	206	80.5%	Total	59	40	70	87	256	100.0%
	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16	Jan-Mar 17	Total	%																															
0-<24hrs	<6	<6	11	9	27	10.5%																															
24-<48hrs	7	<6	7	<6	23	9.0%																															
48+hrs	47	34	52	73	206	80.5%																															
Total	59	40	70	87	256	100.0%																															
Increase in calls to SPA from Care Homes	Overall increase	418 calls to SPA from care homes (Q3. Figures used)																																			

Minimum Data Set

Ref	PROVIDER Performance - Provider Name: NTHFT	Measure	Feb 17	Mar-17	Apr-17	QTR 1
	General Training Element					
1	Total number of Care Homes confirmed as participating	Actual		50	50	50
2	Total number of Care Homes who have confirmed as not participating	Actual		1		1
3	Names of homes who have decided not to participate and the reasons why	Included in quarterly report		See Note		
4	Total number of sessions ran	Actual		19	11	29
5	Total number of sessions ran by NTHFT	Actual		6	2	8
6	Total number of sessions ran by TEWV	Actual		5	2	7
7	Total number of sessions ran by the Stockton Falls Service	Actual		4	4	8
8	Total number of sessions ran by the Hartlepool Falls Service	Actual		-	-	-
9	Total number of sessions ran by Alice House Hospice	Actual		4	3	7
10	Total number training instances	Actual		142	124	266
11	Breakdown/ summary of the staff roles trained	Included in quarterly report		See Note		
12	Total number of sessions cancelled by the Care Home	Actual		3	4	8
13	Names of the Care Homes who cancelled and the reasons why	Included in quarterly report		See Note		
14	Total number of sessions cancelled by the Alliance	Actual	1	1		1
15	Name of the provider who cancelled and the reasons why	Included in quarterly report		See Note		

16	No. of completed questionnaires	<i>Actual</i>		129	118	247
17	No. of Nurses who have accessed support with re-validation process.	<i>Actual</i>	-	-	-	-
18	NEWS: <ul style="list-style-type: none"> Name/ no of homes part of the pilot Homes trained Homes 'gone live' Feedback from stakeholders: Trust, care home staff, residents, families, other relevant staff Community Services, GPs etc. 	<i>Included in quarterly report</i>				

Additional information:

Reference	
Section 1 <i>Total number of Care Homes confirmed as participating</i>	All care homes contacted and have agreed to training, except Wynyard Wood Care Home. Ongoing process of booking dates for homes. To date 17 of the 36 homes in Stockton have confirmed training dates (47%) and 6 of the 14 homes in Hartlepool have confirmed training dates (43%)
Section 3 <i>Names of homes who have decided not to participate and the reasons why</i>	<u>Wynyard Wood Care Home</u> has declined training as they have informed me that they use external companies for their training needs.
Section 11 <i>Breakdown/ summary of the staff roles trained</i>	<ul style="list-style-type: none"> RGN Manager Deputy Manager Head of Personal Care Supervisor Team Leader Senior Carer Night Carer Care Assistant Activities Coordinator Support Worker Administrator Cleaner Domestic Housekeeper Hairdresser Handyman Laundry Assistant
Section 13 <i>Total number of sessions cancelled by the Care Home</i>	<u>Cedar Lodge (March 17)</u> <i>Wellbeing of Elderly & End of Life Care</i> Manager booked wrong date with staff – trainer turned up with no staff available for

	<p>training</p> <p><u>Lindisfarne Care Home (March 17)</u></p> <p><i>End of Life Care</i></p> <p>Manager on leave when trainer arrived at home staff not available for training – Dementia training did take place on the afternoon after call to home</p> <p><u>Elwick Grange (April 17)</u></p> <p><i>Wellbeing of the Elderly & End of Life Care</i></p> <p>Manager unaware the Easter break early in Hartlepool so staff not available for training.</p> <p><u>Hadrian House (April 17)</u></p> <p><i>End of Life Care & Wellbeing of the Elderly</i></p> <p>Manager cancelled training due to D&V in the home.</p>
<p>Section 15</p> <p><i>Name of the provider who cancelled and the reasons why</i></p>	<p><u>Reuben Manor (Feb 17)</u></p> <p>Tees Esk and Wear Valley – Dementia Awareness – Confirmed training with TEWV but date not in trainers diary.</p> <p><u>Wellburn House (Mar 17)</u></p> <p>Tees Esk and Wear Valley – Dementia Awareness – Confirmed training with TEWV but date not transferred to trainers diary.</p>

APPENDIX 7: McKENZIE HOUSE PILOT

McKenzie House – Community Integrated Services Pilot

Summary update on progress – June 2017

1. Purpose

The primary purpose of the Community Integrated Services pilot at McKenzie House GP practice was to encourage closer communication between health and social care practitioners in emergency care planning to help minimise non elective admissions into acute care and decline in care needs leading to admissions into care homes.

The group was set up as part of Hartlepool's Better Care Fund (BCF) plans to ensure the success of an integrated workforce and services between health and social care.

The project scope was to demonstrate improved outcomes for Hartlepool citizens who require support from both health and social care, ensuring that the teams work closely together to help achieve the outcomes set out in the BCF plans, primarily having a cohesive workforce working towards the agreed goal of better care for citizens of Hartlepool.

2. Background

There has always been close partnership work in Hartlepool across health and social care, and excellent examples of when an MDT approach has benefited the citizens of Hartlepool, but this is primarily around discharge processes and namely, the daily discharge planning meeting. Throughout the BCF plans, admission prevention has been a clear aim, but with discharge being a significant pressure on both health and social care, it had become evident that more needed to be done in the way admission prevention and a model developed to help implement prevention plans for the citizens of Hartlepool. Without clear prevention planning, the pressures on health and social care and discharge specifically, will continue to grow. The McKenzie House pilot was developed with this in mind.

The McKenzie House scheme agreed to carry out an initial pilot with one GP practice to establish proof of concept to establish whether having weekly MDT meetings would have a positive impact on admission avoidance for those discussed with representatives from both health and social care, across a variety of community and acute settings, could positive impact on admissions and quality of life.

3. Weekly MDT

Initially, cases were selected based on:

- Care home visits from a GP
- Home visits from a GP in the last three months
- COPD patients

Working principles of the weekly group included:

- Each team to bring forward their own cases for discussion and review as their own agenda items.
- Where possible, each organisation to bring their own electronic devices with access to their own databases/systems for review within the meeting.
- Each member to come prepared with updates on their own cases.
- Each member to nominate cases for discussion
- A discussion of previous cases reviewed to be undertaken during the initial stage of the meeting.
- 6 cases minimum to be discussed each week as “new” cases.

4. Organisations Involved

Representatives attended a weekly operational group to consider an identified cohort of patients in a cohesive, joined up way, and a monthly steering group was established to consider findings, evidence and sustainability of new ways of working established as part of the pilot.

Organisations included: General practice (GP representative), District Nursing, Community Matron, TEWV, Care Co-ordinators, social worker, CIAT, hospital at home, discharge liaison and specialist respiratory nurse.

The steering group considered the measures of success using national and local indicators and how intelligence can be triangulated. An evaluation report is being prepared and will be shared when available.

APPENDIX 8: SPA CLINICAL TRIAGE PERFORMANCE

Single Point of Access Clinical Triage Nurse Evaluation Report

January – March 2017

Emma Campbell

Head of Nursing – Out of Hospital Care

May 2017

Purpose

Following on from the initial evaluation report for the period of August to December 2016, this paper provides further detail of the activity within the Single Point of Access (SPA) Clinical Triage Nurse service for January to March 2017. For the purpose of comparison the whole activity data for the period of the pilot has been included in this report.

Chart 1 below demonstrates the number of calls that have been dealt with through Clinical Triage. This information shows that the activity continues has continued to increase since the implementation of the service in August 2016.

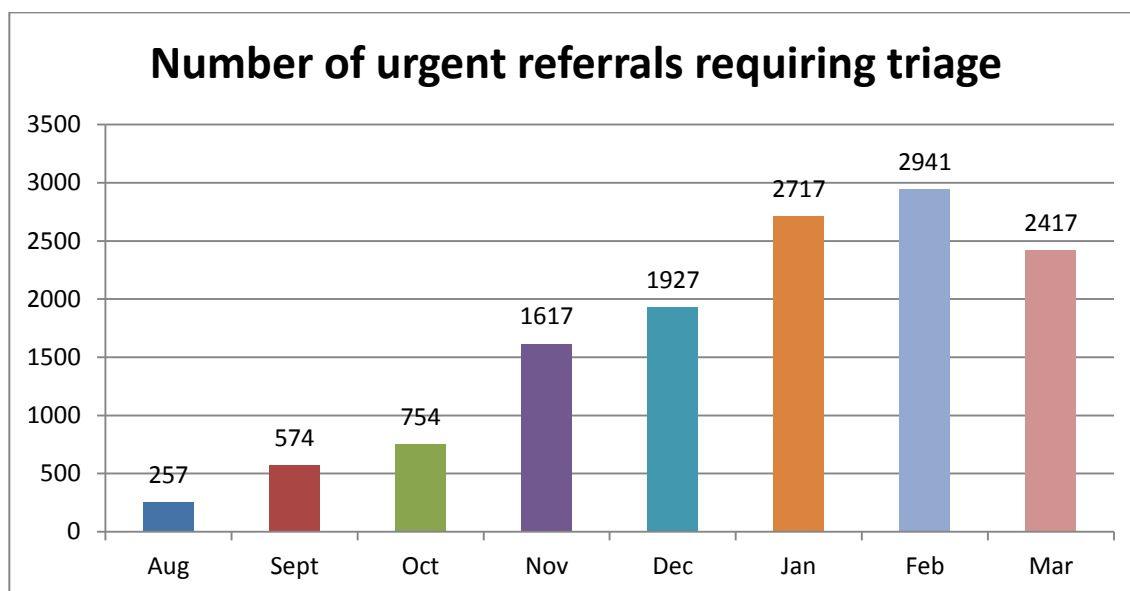


Chart 1: Number of urgent referrals triaged from 1st August 2016 to 31st March 2017.

The chart below provides a breakdown of the number of referrals per locality. The highest number of referrals are made from the Stockton region which is reflective of the population size.

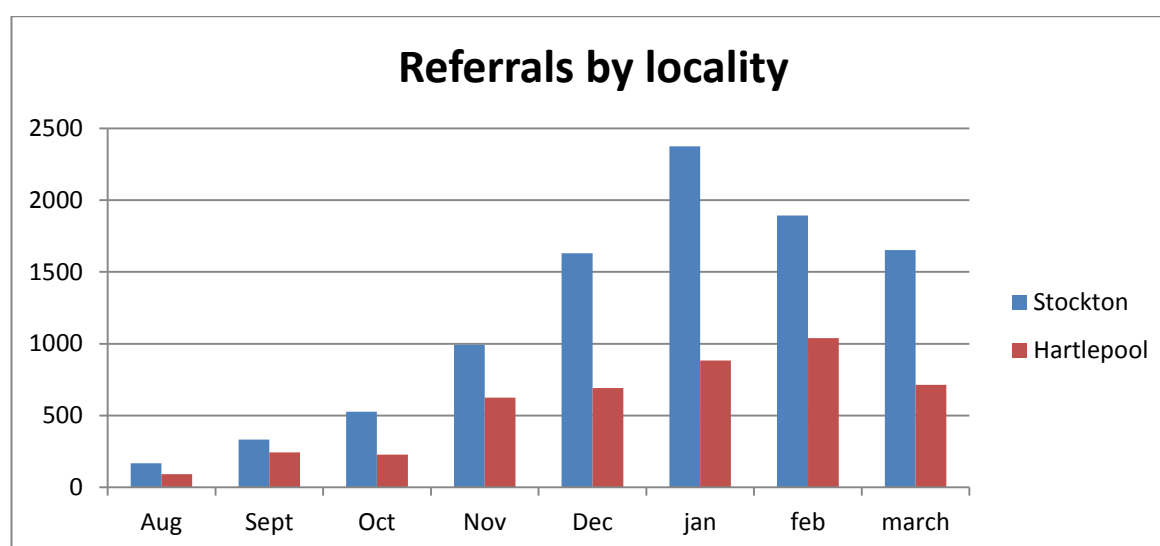


Chart 2: Referrals by locality.

Chart 3 provides a breakdown of those referrals that were actioned via Clinical Triage for people aged 65+. It was reported in the initial evaluation paper that the increase in calls for November correlated with the introduction of the revised Community Matron service. Although this figure dropped in December, it is evident that there has been a significant increase in referrals between January and March.

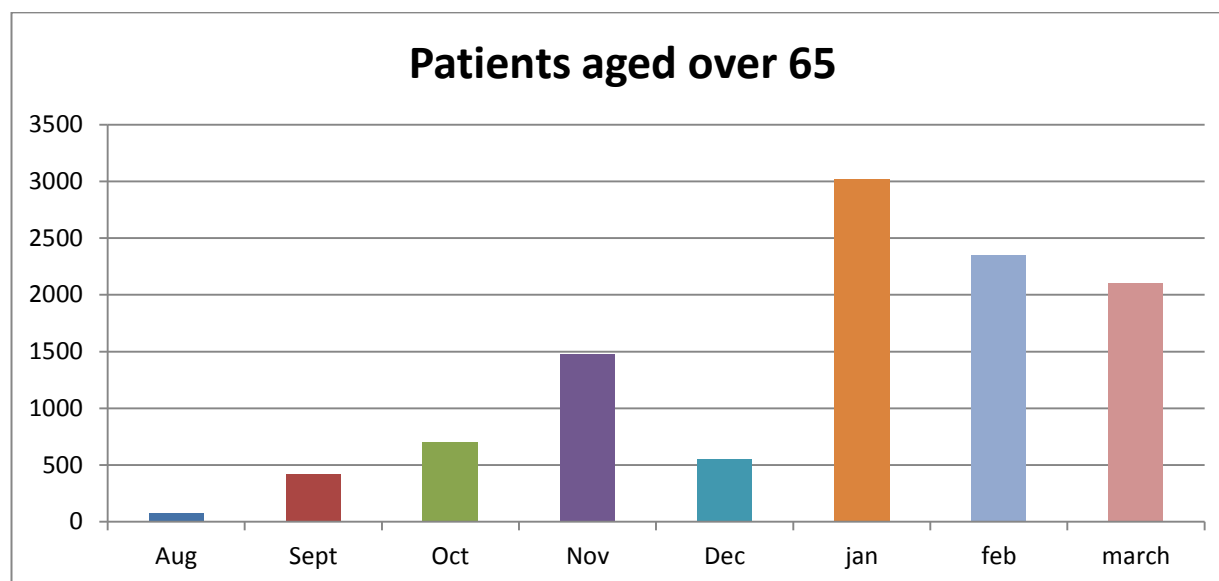


Chart 3: Number of patients passed through Clinical Triage Nurse for 65+.

Chart 4 below demonstrates the number of referrals that have been signposted to the appropriate service following Clinical Triage involvement.

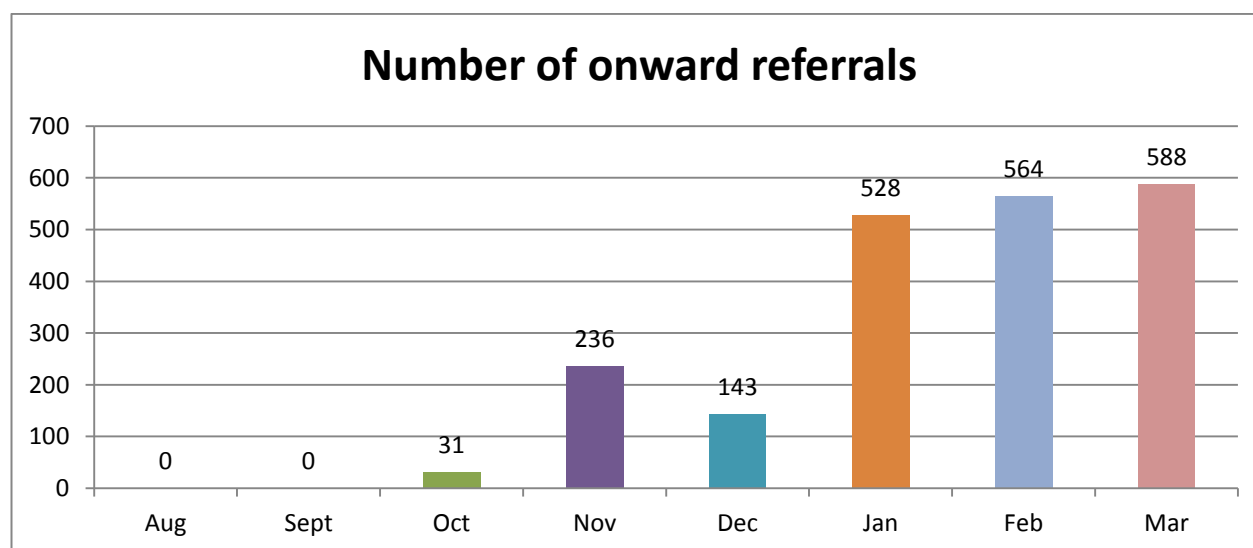


Chart 4: Clinical Triage – onward referrals

This information could suggest that without Clinical Triage, a significant number of patients would have experienced a delay in receiving the right service at the right time. Prior to clinical Triage, these referrals would have been handed to a community team which may have not been the appropriate service to carry out the initial visit which then results in further onward referral that not only impacted upon clinical time, but also upon the patients' experience of Our of Hospital Care services.

Chart 5 provides further information in relation to the number of referrals that were deemed inappropriate for the original requested service. Appendix 1 provides details of case studies where the Clinical Triage Team have had a positive impact in relation to dealing with inappropriate referrals.

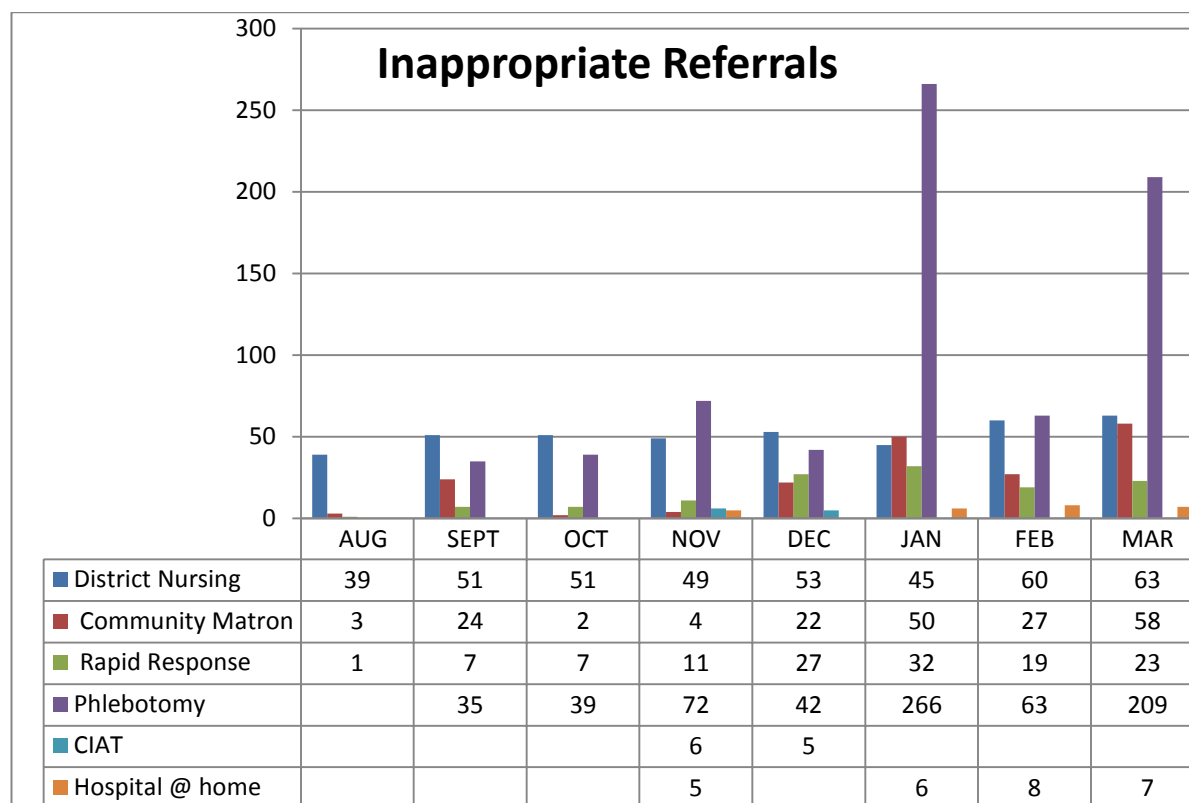


Chart 5: Inappropriate referrals per service

As stated in the previous report, these referrals were either signposted to the appropriate team or handed back to the referrer by the Clinical Triage Nurse through discussion, for example with the originating GP Practice or ward. It is interesting to note that phlebotomy continues to receive the highest number of inappropriate referrals. This is illustrated further in chart 6.

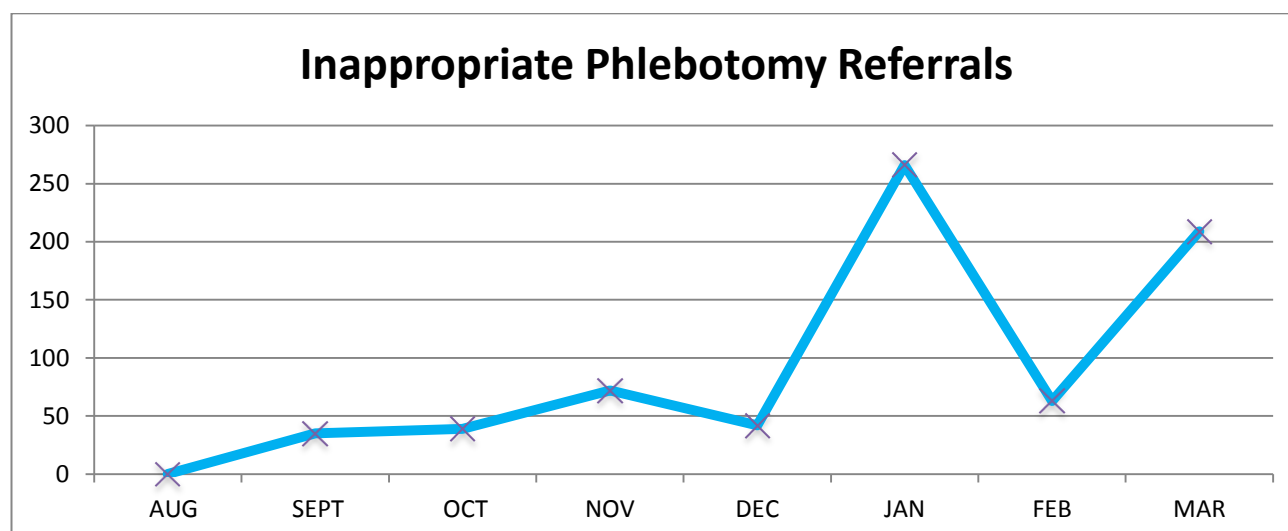


Chart 6: Number of referrals for phlebotomy deemed inappropriate.

5. Conclusion

This report demonstrates that the Clinical Triage service is continuing to have a beneficial effect on community services. Discontinuation of this service could have a detrimental effect upon clinical capacity as well as impacting upon the patient and referrers experience.

Appendix 1

Case Studies

The following case studies demonstrate the benefit of the Clinical Triage Nurses within the Single Point of Access:

Case Study One:

A referral was received into district nursing to administer tinzaparin injections the Clinical triage nurse identified from the referral the patients INR was unstable. This is an inappropriate referral to the district nursing team and was therefore redirected to the rapid response team. The triage nurse understanding the services delivered by the community teams ensured the patient was seen by the right clinician at the right time. The role of the Clinical Triage Nurse in this instance meant that although the referral was made for the incorrect team there was no delay in care delivery.

Case Study Two:

A referral was received into the Hospital@Home service to visit a patient in a care home with a possible chest infection. Patient symptoms were increased cough, chesty and coughing up phlegm. The triage team contacted the referrer for further information. On clarifying the patient details it was determined that the patient did not have a diagnosis of COPD. Therefore the Hospital@Home team are not the correct service to assess the patient. The triage team on obtaining further information and using their knowledge of community nursing teams were able to use the information from their triaging of the patient to refer to the community matron service. This meant the patient was assessed appropriately by the correct clinician at the correct time. The potential outcome following triage is the prevention of an avoidable hospital admission.

Case Study Three:

A referral was received asking for district nurses to provide support once a day for meal preparation for a post-operative patient. The Clinical Triage Nurse contacted the ward for further information following this it was identified the patient had no medical needs and was fit for discharge but would require assistance with meal preparation short-term following surgery. Clinical Triage were able to identify that district nursing was not the appropriate service for this referral and were able to identify that support could be provided to facilitate the discharge of this patient by referring to the rapid response team. The Clinical Triage Nurse advised the discharging ward that the referral would be passed to the rapid-response team to facilitate the discharge and provide support. The referral was sent to the rapid-response team who facilitated a safe discharge within the community. The referral was ended in district nursing. This outcome meant the patients discharge was not delayed whilst they waited for a social

services care package to be implemented. Following acceptance for support by the Rapid Response Team a full assessment of need would be made on discharge and a referral made to social services for on going care if required.

All three case studies demonstrate how the referral was triaged and transferred to a more appropriate service. The Clinical Triage team were able to use their extensive knowledge of community services to ensure the referrals were redirected to the most appropriate support service at the right time, enabling the individual to maintain safety within their own home. As illustrated in the case studies, the Clinical Triage team also provide the added reassurance that referrals will reach the right service within an appropriate response time, therefore reducing the risk of a referral being rejected if sent to the wrong service.

APPENDIX 9: PHARMACY SUPPORT INTO CARE HOMES Performance Report

North of England Commissioning Support

Medicines optimisation Support to Care Homes/Social Care in Hartlepool

Annual Report 2016



Document Summary	
Directorate:	Commissioning Support, Medicine Optimisation
Document Purpose:	Annual Report 2016
Document Name:	Medicines optimisation Support to Care Homes/Social Care in Hartlepool
Document Ref No.	MOCHT BCF16
Author:	Kathy Thornton
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Superseded Document:	N/A
Action Required:	N/A
Contact Details (for further information and feedback)	Kathy Thornton Medicines Optimisation Pharmacist Tel: 07824528662 E-mail: kathythornton@nhs.net
Document Status	
<p>This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled.</p> <p>As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.</p>	

Version	Date	Summary	Owner's Name	Approved
1	20.4.17	Annual report 2016	Kathy Thornton	
2				
3				

Table of Contents

Document Summary	124
1. Introduction.....	126
1.1. Background	126
1.2. Rationale for service	126
1.3. Scope of Service	126
1.4. Key Performance Indicators.....	127
1.5. Purpose	127
1.6. Key points.....	127
2.0 Development, management and validation of self-assessment audits	128
2.1 Provision of advice around Medicines policy	128
2.3 Provide specialist medicines optimisation advice and respond to queries in support of Adult Care Teams with regard to legislation and best practice around the prescribing, supply, dispensing, storage and administration of medicines within care settings.	130
2.4 Provide specialist, bespoke training, for all care teams, tailoring material to address the needs of the individual teams.	131
2.5 Referral of patients for full medication reviews to the MO practice team care home service	131
2.6 Future activities	131
3.0 Key Performance Indicators	133
Appendix 1	134
Activity Log – January 2016- January 2017	134

Medicines Optimisation Support to Care Homes/Social Care in Hartlepool

Annual Report 2016

1. Introduction

1.1. Background

In November 2015 NECS was commissioned by Hartlepool Borough Council and Hartlepool and Stockton-On-Tees CCG (through the Better Care Fund) to:

- Provide expert knowledge in the delivery of safe and effective medicines management to service users in receipt of social care / NHS funded care.
- To develop use of assessment tools based on current best practice to help identify to care homes where improvements to current practice can be made.
- To make appropriate interventions in care homes

Hartlepool Borough Council provided NECS with a list of appropriate commissioned services to be targeted through this scheme. The service was commissioned for one year to start January 1st 2016.

1.2. Rationale for service

The Care Quality Commission (CQC) inspects and regulates adult social care services. A new approach to these inspections started in October 2014, and all care homes are to be assessed using the new rating system. Ratings and reports are published on the CQC website www.cqc.org.uk

During the period of October 2014 to October 2015 a total of 23 out of 33 providers (70%).were rated by CQC with 13 providers (39%) rated as inadequate or requiring improvement with medication being identified as an area for concern.

1.3. Scope of Service

- Development, management and validation of self-assessment audits,
- Provision of advice around Medicines policy ,
- Work with key stakeholders and support information sharing which will include learning from medicine incidents,
- Provide specialist medicines optimisation advice and respond to queries in support of Adult Care Teams with regard to legislation and best practice around the prescribing, supply, dispensing, storage and administration of medicines within care settings,
- Provide specialist, bespoke training, for all care homes tailoring material to address the needs of the individual teams. (Induction/level 3 medication training remains the

responsibility of the care provider). Examples of training might be covert medication /medication reconciliation/when required)

- Referral of patients for full medication reviews to the MO practice team care home service

1.4. Key Performance Indicators

- All defined services will receive an initial assessment to understand their requirements. These will be prioritised working with the CCG and Local Authority. Thereafter they will receive a minimum of a six-monthly monitoring visit.
- Report and recommendations provided to each manager following a monitoring visit; minimum target 100%.
- Pharmacist /Pharmacy Tech to attend forums as required. (No more than quarterly).
- Pharmacist to support learning from incidents.
- Production of quarterly reports evidencing Service delivery and progress against agreed key performance indicators for the Service.

1.5. Purpose

The purpose of this document is to provide a summary of activity and support delivered by, Medicine Optimisation team (MO) in delivering the Service Level Agreement to care homes/social care in Hartlepool.

1.6. Key points

This report will provide information on areas of activity delivered by the medicines optimisation team including:

- overview of care home support activities
- key performance indicator targets
- future working and planned activity

2.0 Development, management and validation of self-assessment audits

The MO team developed a comprehensive self-assessment audit based on NICE guidance and best practice for administering medicines (this is updated on a regular basis to incorporate any changes in legislation and medicines alerts). The service ensures that care homes are supported to complete this self-assessment and where necessary identify areas where improvement can be made. The care home is then supported to produce and implement an action plan for improvement. As part of the validation, the service delivers a mini audit to ensure the action plan has been satisfactorily implemented before completing a full audit on the standard of medicines management within the care home.

In the second half of the year the mini audit is repeated to check standards are maintained. Where standards are not met, the team produces a second action plan for implementation before an end of year assurance audit is completed. The care home manager and the commissioners are kept up to date at all times by both face to face regular meetings and emailed confirmation of advice given together with copies of action plans. The time scales for completion of self-assessment and validation are included in appendix 1.

- Intended outcomes from this process are as follows: At the end of the year all care homes can demonstrate that they have implemented action plans for improvement.
- At the end of the year the medicines optimisation team can give assurance of the standards for medicines optimisation In December 2016 this was achieved in 23/24 of the designated care settings.
- A monthly update of care home standards can be shared with HBC and the NECS quality Team
- A quarterly update of care home standards can be provided to Hartlepool BCF group.

2.1 Provision of advice around Medicines policy

- The service has provided advice to 24/24 care homes about what policies are recommended and what each policy should contain. At the end of the year 24/24 homes had the recommended policies in place. The service has supported the 4/4 home care providers to develop medication risk assessment tools together with policy and procedures for safe handling of medicines for people supported in their own homes .
- All care homes have Medicines management folders (all emailed documentation is printed and stored in this folder so all carers have access to information).
- All Care Homes/home care providers have contact details for medicines support.
- All care homes have access to online resources.
- Details of no of advice visits and documentation requested is provided in appendix 1

Intended outcomes from this is the care providers in Hartlepool have robust policies and procedures in place so that people in Hartlepool who are supported to take their medicines in a safe way.

CQC during their regulatory inspection give judgement on the proper and safe use of medicines. Between January and December 2016, the CQC published 10 reports on inspections of Hartlepool care homes, in these inspections no concerns were reported relating to medicines.

2.2 Work with key stakeholders and support information sharing which will include learning from medicine incidents.

The MO team formed part of a working group with the Performance, Audit and Quality (PAQ) Sub-Group of the Tees-wide Safeguarding Adults Board (TSAB) to undertake a medication audit to enable a better understanding of the issues in relation to medication errors and the level of reporting into safeguarding. The findings, conclusions and recommendation from this working group will be presented to the TSAB. The MO team has provided guidance pack on identifying managing and reporting incidents to 24/24 care homes.

Hartlepool Safeguarding team now routinely inform the MO team of all “no further action” incidents reported regarding medication. The MO team record a brief summary of each incident in the monthly report. (These incidents have all been investigated by the care manager) The MO team reviews each incident to get an overview of what sorts of incidents are reported and in which care setting they are occurring. The MO team check that full learning has taken place. The MO team visited care homes and checked on 17 from the 43 incidents that were received from the Safe Guarding team throughout the 12 month period.

Examples of when the team have further intervened are typically

- When medicines are given to the wrong person
- When medicines are not available for administration
- When processes for medication changes have not been followed

Examples of when the medicines team have not intervened further are

- When the care home has identified individual staff failings and have addressed through training supervision or disciplinary actions.

An example of how the service has supported change in practice as a result of a ‘near miss’ incident is that now Roseberry Park issue FP10-prescriptions for care homes. This means that the community pharmacy that dispenses the rest of the resident’s prescription can now pick this prescription up, dispense into the MDS system and issue printed MARS together with the rest of the prescribed medicines. Previously, as the service had a contract with a community pharmacy to dispense prescriptions, the care homes had to arrange collection for the dispensed medicine which was supplied in original boxes without a printed MAR. Having medicines prescribed by different services is a risk when this is compounded by the medicines being dispensed in different systems from different pharmacies without printed MARs put the resident at an unnecessary risk.

See Appendix 1 for examples of where visits were made to ensure lessons were learnt and shared. Whilst we do not have data from previous years to compare to, an increase in referrals should not be seen as a negative, but as an increase in competence at identifying and reporting incidents. A study back in 2009(CHUMS) revealed that on any one day, seven out of ten residents (receiving more than 8 medicines a day) experience mistakes with their medication, ranging from doses being missed or given incorrectly. Whilst improved systems will reduce the risk of incidents, given the

number of medicines administered in any care setting on any one day, it is unlikely that no incidents occur over a year.

2.3 Provide specialist medicines optimisation advice and respond to queries in support of Adult Care Teams with regard to legislation and best practice around the prescribing, supply, dispensing, storage and administration of medicines within care settings

The Medicines Optimisation team is available between 8.30 and 5.30 for 52 weeks a year via email and telephone to answer any queries. We receive typically 2-3 phone calls each week requesting some kind of intervention and send emails backing up verbal advice given at the time of visits.

Typical queries:

- covert administration of medicines
- help to synchronise medicines
- managing refusal of medicine administration
- storage and disposal
- controlled drug issues including management of discrepancies
- liaison across other healthcare service interface e.g. community pharmacy or GP practices
- management and recording of “as required” medicines

Documents have been developed such as:

- Specialist MAR charts to accurately record the use of non-oral prescribed products such as creams, patches, injections, sip feeds and leg bags.
- When Required protocols and guidance
- Stock recording sheets to ensure accurate stock balances are kept
- Agreed responsibilities for visiting professionals administering medicines
- Covert administration.
- Incident Reporting
- Expiry dates and Specialist Storage Requirements

Details of when requests have been made for additional documentation are attached in Appendix 1.

All documents are available on the NECSU website <http://medicines.necsu.nhs.uk/necs-good-practice-guidance-and-tools-for-care-homes/> Download numbers are recorded.

The medicines optimisation team additionally support the care homes to synchronise prescriptions with the GP surgery, this both limits the risk of residents of residents not receiving their medicines and minimises disruptions in the care home, GP practice and community pharmacy.

The team provide proactive advice to care homes via a Medicine Matters newsletter. The publication aims to provide medicine related information to staff in care homes that is current, informative, interesting and relevant to their work.

Information included in newsletters include “learning from incidents” and topical articles such as avoiding acute kidney injury, as well articles on how to ensure medicines are always stored and administered correctly. In this way, key messages can be sent to all care home managers and staff on a regular basis whilst providing a contact point if needed for further information.

A summary of each month progress is shared with the commissioning team at Hartlepool Borough Council.

2.4 Provide specialist, bespoke training, for all care teams, tailoring material to address the needs of the individual teams.

Care homes are actively encouraged to book training sessions.

Onsite coaching for on-duty staff members is done as a matter of routine during visits. With regard to formal training, all care homes have had specific training on recording administration with specific attention to ‘when required’ and ‘covert administration’. In addition, all care homes have had training on incident management and reporting.

Additionally 4 specialist training sessions were delivered during 2016. Appendix 1 describes detail regarding the types of training delivered to care homes.

2.5 Referral of patients for full medication reviews to the MO practice team care home service

The MO practice team support care home medication reviews in 3 ways

1. Pharmacist that visits the care home to carry out in depth medication review
2. Pharmacists that review prescription records of care home practice following an agreed work plan
3. Pharmacy technicians that visit care homes following an agreed timetable to minimise waste medication

MO work plan report indicated 46 requests for a specific medication review came from the MO care team.




2.6 Future activities

During 2017 it is anticipated that the core service will continue as per the current Service level agreement. Specific areas of work to be focussed on are as follows and will be developed further.

Proposed plans from the MO team include

- Training sessions to GP practice teams, this will increase the understanding of practice teams around the specific issues care homes have with ordering and supply of prescriptions
- Implementing On-Line ordering for Care Homes.
- Training sessions on Controlled drugs
- Training on Homely Medicines

3.0 Key Performance Indicators

Key performance indicators	Target	Q1	Q2	Q3	Q4
		Red (not achieved) Green (achieved)	Amber (on target or not fully complete) Blue (not scheduled in the quarter)		
Named Staff					
Nominated Lead Pharmacist 8b	100%	Kathy Thornton			
Nominated Support Pharmacy Technician 6	100%	Gillian Smith			
Self-Assessment					
Development and update maintenance of Self-Assessment Tool	100%	5/1/16			
Distribution and support where necessary in completion of self-assessment	100%	15/24	24/24		
Action Plan developed and mini audit to check implementation complete			22/24	23/24	
6 monthly Assurance Audit			24/24		23/23
Report recommendations to manager		100%	100%	100%	100%
Report monthly update of Service to HBC/quality Team					
Quarterly Reports					
Report and recommendations provided to each manager following a monitoring report	100%	 Q1 Hartlepool Support service.docx	 Q2 Hartlepool Support Service.docx	 Q3 Hartlepool Support service(1).dc	In progress
Managers meetings					
Pharmacist to attend care home managers forum on a quarterly basis	each quarter	12/2/2016	25/5/2016		1/11/2016
Pharmacist to attend the domiciliary care provider forum as required			7/6/2016	18/7/2016	8/9/2016
Pharmacist to attend review meeting with HBC commissioning managers		3/3/2016	7/6/2016	17/8/2016	7/12/2016
Learning from Incidents					
Input into medicine related error review and support		2	4	9	2

Appendix 1

Activity Log – January 2016- January 2017

Care home	Training	Date and no. attending	New Documentation	Mar Audit	Med Review Query	Safeguarding Visits	Pharmacy Visits	Number of Medicines Synchronised	Total Number of Visits to each Home
Brierton Lodge				2	1	1			14
Burbank Mews				1		1			16
Charlotte Grange				2	1	2	1		15
Clifton House				2	1	1		17	18
Dinsdale Lodge			GP appointment forms	3	1	1			21
Elwick Grange				1	1				12
Five Penny House			Count sheet Administering meds. On food pathway.	1		1			10
Glendale				1					6
Greenfield				1					11
Gretton Court			Transdermal patch chart	1	1				12
Lindisfarne Care Home				1	1			6	14
Manor Park	Covert	21/4/16 6		4	3				16
Queens Meadow Care Home				7	2	1		35	27
Rosedale & Rosewood	count sheets	16/6/16 4	Count sheets	2		3			17
Seaton Hall Care Home				7	1		2	10	32
Seymour House	Prn recording	12/5/16 3		1	1	1	1		21
Sheraton Court				2	1	1			13
Stitchell	checking in meds	20/9/16 4	GP appointment forms	1			1		17
South Highnam			Administration on food form	1	1	1			12
The Crescent				1	1			3	10
Warrior Park Care Home				7	1	3			24
Westview Lodge Care Home			Protocol for Jubilee unit	2	1		1	9	39
Wynyrd Woods				4					16
Wordsley house									2
All care homes			meds opt. file prn and covert documentation						
			Quarterly newsletters						
			Incident reporting pack						

APPENDIX 10: Home from Hospital

Hospital of God – Home from Hospital Service

May 2017 Update

1. Purpose

This initiative centres on coordinating care within an acute setting, eliminating unnecessary length of stay in hospital in order to free up beds and facilitate appropriate discharge back to individuals homes, for patients who have little to no support and are not in receipt of care from statutory services. The service went live in early May 2017 and has a two year contract.

It involves partnership working with the Integrated Discharge Team, working closely with the acute hospital services including wards, and the Hospital of God as service provider. Older patients who are frail or socially isolated (some of whom may have dementia) can do less well in hospital due to communication and cognitive difficulties.

The Home from Hospital service will provide the following service;

- Support pre and post discharge to people going back to their own home as part of the discharge to assess pathway. There is an expectation that this service will support individuals for up to 7 days and beyond this only in exceptional service at the discretion of the provider, which the provider will report to commissioners via contract monitoring
- A service between the hours of 9am to 8pm Monday to Saturday 52 weeks per year (including bank holidays)

The service can be accessed by people aged over 65 who live in the Hartlepool locality who may find themselves in a hospital environment who are with little to no family support and are doing less well due to sensory loss, general frailty and more complex needs following a stroke, cardiac issues and other co-morbidity factors. It will support carers as well who may be elderly and struggle to cope and become ill themselves, thus preventing carer crisis.

The Home from Hospital Service will receive referrals from the Discharge Liaison Team from North Tees and Hartlepool FT. The service will work closely with the discharge liaison team in order to identify appropriate referrals and will then liaise with the ward and the individual

to assist in the discharge plan. This will ensure individuals are discharged home safely with the appropriate support.

2. Service Focus

- Focussing on individuals over the age of 65 who do not currently have a care package in place
- Liaison with hospital at all stages in a care episode to ensure all parties have the information they need to care for the patient appropriately.
- Liaison with the hospitals Integrated 'Discharge to Assess' team and to plan for the return home and take actions required to ensure that the place of residence is ready for someone who is feeling more fragile than usual (home preparation).
- Ensuring that any carers are involved with and kept informed of any discharge plans

3. Exclusion criteria:

- Individuals living in a care home
- Individuals under the age of 65
- Individuals within CHC
- Individuals with a package of care already in place

4. The key service outcomes:

- Contribute to the reduction of inappropriate admissions and re-admissions to hospital and care homes
- Contribute to the reduction of delayed transfers of care in the acute setting by supporting the discharge to assess pathway
- To work with discharge liaison and, lower levels of health intervention post-discharge
- Care for an ageing population in an acute setting to support and facilitate a speedier discharge.
- Bring care closer to home
- Signpost to appropriate services should this be required following engagement in the service

- Access to health promotion information and education
- Improved quality of life

APPENDIX 11: INTEGRATED DIGITAL CARE RECORDS UPDATE

All barring one GP Practice in Stockton and Hartlepool are signed up to sharing data through the Medical Interoperability Gateway (MIG). This will enable 10 datasets from GP Primary Care records to be made available to clinicians in 15 providers (Acute Trusts, Mental Health Trusts, OOH Providers) across the North East to inform decision making at the point of care. Following the Practice sign up, the technical roll out of the MIG system in the Providers is ongoing with the system being available and used by April 2017. There is a phased roll out of the use of the system in NTHFT. The first phase making the MIG available in A&E, followed by it being available in Urgent Care. Based on the success of the first two phases the MIG data will be rolled out to be available to clinicians Trust wide, but this is reliant upon updates to the data sharing agreements currently in place with the practices.

The next step is to make an appropriate set of the GP data available to Social Care through the MIG. From a demonstration with social care workers, it was identified that only 8 of the 10 datasets were appropriate to be viewed in social care. To achieve the roll out in social care the following steps are required:

- Complete a Privacy Impact Assessment to explain why the data is to be shared, what will be shared and who with. This has been actioned and shared with Practice Managers in both Hartlepool and Stockton.
- Develop a Data Sharing Agreement for the sharing of data from GP systems to social care and set up the Local Authorities on the Information Sharing Gateway which will be the portal for the data sharing agreements.
- Communicate with GP Practices to get the Practices on board with sharing with social care. This was discussed with Hartlepool Practice Managers at the end of April 17 and with Stockton Practice Managers in the beginning of May 17. Stockton Practice Managers raised concerns regarding the level of data they receive from Social Care and would like this issue resolving before they would open up the sharing of data through the MIG with Social Care. This process should hopefully open up the opportunity to improve the data sharing between both parties.
- Once we have agreements for the sharing of data with social care, then to procure the system and licences.

The Great North Care Record are currently developing a specification for a system to provide Integrated Digital Care Records across the North East. All partners that have been involved in the development of the Integrated Digital Care Record as part of the BCF IT Strand have been invited to inform the GNCR specification.

