HEALTH AND WELLBEING BOARD AGENDA

HARTLEPOOL BOROUGH COUNCIL

Monday 13 June 2016

at 2.00 p.m.

in Committee Room 'B'
Civic Centre, Hartlepool.

MEMBERS: HEALTH AND WELLBEING BOARD

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors C Akers-Belcher, Buchan, Clark and Thomas
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group (2) – Dr Timlin and Alison Wilson
Director of Public Health, Hartlepool Borough Council (1); - Louise Wallace
Director of Child and Adult Services, Hartlepool Borough Council (1) – Sally Robinson
Representatives of Healthwatch (2). Margaret Wrenn and Ruby Marshall

Other Members:
Chief Executive, Hartlepool Borough Council (1**)** – Gill Alexander
Director of Regeneration and Neighbourhoods, Hartlepool Borough Council (1) – Denise Ogden
Representative of the NHS England (1) – Audrey Pickstock
Representative of Hartlepool Voluntary and Community Sector (1) – Tracy Woodhall
Representative of Tees, Esk and Wear Valley NHS Trust (1) – Colin Martin
Representative of Cleveland Police, Temporary Assistant Chief Constable Ciaron Irvine

Observer – Statutory Scrutiny Representative, Hartlepool Borough Council

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To confirm the minutes of the meeting held on 29 April 2016
   3.2 To receive the minutes of the meeting of the Children's Strategic Partnership held on 25 January 2016

4. **ITEMS FOR CONSIDERATION**

4.1 Review of Terms of Reference – *Director of Public Health*
4.2 Introduction to new GP Federation – Presentation – *Dr P Williams*
4.3 Sustainability and Transformation Plan - *Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*
4.4 Better Health Programme – Presentation – *Chief Officer, Hartlepool and Stockton-on-Tees Clinical Commissioning Group*
4.5 Assisted Reproductive Unit at the University of Hartlepool Hospital – Update - *Director of Public Health*
4.6 Better Care Fund 2015/16 Quarter 4 Return – *Director of Child and Adult Services*

5. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

Date of next meeting – 11 July 2016 at 10.00 am in the Civic Centre, Hartlepool.

HEALTH AND WELLBEING BOARD

MINUTES AND DECISION RECORD

29th April 2016

The meeting commenced at 9.30 am in the Civic Centre, Hartlepool

Present:

Councillor C Akers-Belcher, Leader of Council (In the Chair)

Prescribed Members:
Elected Members, Hartlepool Borough Council – Councillors Cranney (as substitute for Councillor Richardson) and Chris Simmons
Representatives of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Dr Schock and Karen Hawkins (as substitute for Alison Wilson)
Representative of Healthwatch –Margaret Wrenn
Other Members:
Representative of Cleveland Police – Chief Superintendent Gordon Lang (as substitute for Simon Nickless)

Officers: Kelly Bainbridge, Better Care Fund Project Manager
Joan Stevens, Scrutiny Manager
Amanda Whitaker, Democratic Services Team

61. Apologies for Absence

Elected Members, Hartlepool Borough Council – Councillors Carl Richardson and Paul Thompson
Representative of Hartlepool and Stockton-on-Tees Clinical Commissioning Group – Alison Wilson
Director of Child and Adult Services, Hartlepool Borough Council – Sally Robinson
Director of Public Health, Hartlepool Borough Council - Louise Wallace
Chief Executive, Hartlepool Borough Council – Gill Alexander
Representative of Hartlepool Voluntary and Community Sector – Tracy Woodhall
Representative of Cleveland Police – Simon Nickless
Representative of Healthwatch - Ruby Marshall
Representative of Tees Esk and Wear Valley NHS Trust – David Brown

62. Declarations of interest by Members

None

63. Minutes

The minutes of the meeting held on 14 March 2016 were confirmed.

64. Better Care Fund Plan (*Director of Child and Adult Services*)

The Better Care Fund Plan for 2016/17 was presented to the Board for approval. Guidance had been published on 23 February 2016 regarding Better Care Fund Planning Requirements for 2016/17. The guidance set out eight conditions which local areas needed to meet as detailed in the report.

Also presented were the following planning requirements together with the timetable for submissions:-

- A jointly agreed narrative plan including details of how national conditions are being addressed;
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
- A scheme level spending plan demonstrating how the fund will be spent;
- Quarterly plan figures for the national metrics.

It was noted that the Plan for 2016/17 had been developed by the Council and the CCG with input from providers and built on the priorities agreed in the 2015/16 plan. The BCF Plan narrative document for 2016/17 was appended to the report. The planning template that supported the narrative plan set out in further detail the specific funding requirements; expenditure plan for 2016/17 and target setting for metrics. The BCF Planning Template for 2016/17 was appended to the report**.**

Board Members were advised that there was a requirement in 2015/16 for quarterly performance reports to be signed off by the Health and Wellbeing Board and submitted to the Department of Health, with the Q4 return for 2015/16 due to be submitted by 27 May 2016. This reporting requirement would continue for 2016/17 but dates for quarterly returns to be submitted had not been issued.

It was noted that the BCF Pooled Budget had been fully committed in 2015/16 with slippage used to support one off pressures in adult social care and Disabled Facilities Grants. Plans had been agreed that fully committed the budget for 2016/17 and the budget would continue to be monitored throughout the year through the Pooled Budget Partnership Board. There was a requirement to have a signed s75 Partnership Agreement in place by 30 June 2016.

The Better Care Fund Project Manager and the Associate Director of Commissioning and Delivery responded to questions arising from the report. It was recognised that there was a necessity for the Plan to accord with the

concept of bespoke community hubs. Discussion followed on issues associated with social isolation and the role of GPs in ensuring connectivity with other agencies and health professionals. The Board was assured that the Better Care Fund Plan aimed to bring together other plans and a proactive approach was envisaged. An allocation to care co-ordination would be in place this year in GP practices and would link to early intervention services, although it was recognised that not all access was through GPs.

Board Members highlighted staffing issues and difficulties associated with the recruitment of nurses. A number of areas were identified in relation to addressing recruitment issues, although it was recognised that not all those issues could be addressed through the Better Care Fund Plan. Reference was made to the operation of a 6 day model of working and the Chair of the Board advised that the Finance and Policy Committee had agreed to locate social workers at hospital based on a 7 day business case model. The Chair highlighted that the change to the model had not been reported to Finance and Policy Committee. The Board was advised that the decision had been made by Pooled Budget Partnership Board. However, the Chair advised that there had been a charge against the Local Authority budget. It was considered that an update report should have been submitted to Committee in relation to arrangements which it was recognised were outside the remit of the Better Care Fund.

The Chair sought clarification regarding a proposal to 'means test' telehealth and telecare services and how that would accord with the Better Care Fund. Whilst endorsing the Better Care Fund Plan, it was requested that a report be submitted to the Board on the impact of the Fund. The Board was advised that it would be necessary to set performance measures and outcomes. Stockton Borough Council had recently been successful in a bid relating to funding impact and that work would be linked to Hartlepool. A Working group had been convened to determine reporting and performance measures to determine outcomes delivered by services and a model was being worked up.

The Chair requested that for each scheme funded through the Better Care Fund monies, there was a clear overview and review of each service to indentify the outcomes that would be delivered. The Chair requested that this be provided in the future alongside the performance reports to the Board.

In response to clarification sought from an Elected Member, the representative of Cleveland Police acknowledged that it was essential for Partners to work together and advised the Board of a number of preventative initiatives which had been introduced including Cleveland Connected.

Decision

(i) The Board approved the 2016/17 BCF Plan and agreed to receive quarterly updates throughout the year.

(ii) It was agreed that a report be submitted to the Board detailing the impact of the Better Care Fund.

Meeting concluded at 10.20 a.m.

CHAIR

CHILDREN'S STRATEGIC PARTNERSHIP

MINUTES AND DECISION RECORD

25 JANUARY 2016

The meeting commenced at 4.15 pm in the Civic Centre, Hartlepool

Present:

Councillor Chris Simmons (In the Chair)

Also present: Danielle Swainston, Assistant Director, Children's Services
Lindsey Robertson, Hartlepool and North Tees NHS Foundation Trust
Nicki Smith, CAMHS, Tees, Esk and Wear Valleys NHS Trust
Helen White, Participation Manager
Dave Wise, WVARC, (Voluntary and Community Sector Representative)
Kay Glew, Housing Hartlepool (Thirteen Group)

Dave Pickard, Independent Chair, Hartlepool Safeguarding Children Board
Martin Todd, Changing Futures North East
Dominic Luscombe, iMPOWER
Deborah Crossan, iMPOWER

Young Peoples Representatives:
Callum Reed, Jannat Khanum, Sara Razzaq, Lauren Howells, Adam Shillaw and Abby Wallace.

Officers: Jane Young, Head of Service, South Locality
Chris Rooney, Head of Service, North Locality
Deborah Clark, Health Improvement Practitioner
David Cosgrove, Democratic Services Team

15. Apologies for Absence

Sally Robinson, Director of Child and Adult Services
Mark Patton, Assistant Director, Education
Louise Wallace, Director of Public Health
Damien Wilson, Assistant Director, Regeneration
Chief Superintendent Gordon Lang, Cleveland Police
Ali Wilson, Hartlepool and Stockton-on-Tees Clinical Commissioning Group
John Hardy, Headteacher Representative, Primary Schools
Darren Hankey, Post 16 Education Representative.

16. Declarations of Interest

None.

17. Minutes of the meeting held on 17 November 2015

Confirmed.

18. Delivering the Better Childhood and Health Relationship Programme (*Director of Child and Adult Services*)

The Assistant Director, Children's reported that following the November meeting a 'vision document' had been developed outlining the aim, vision and 'collective obsessions' for partners delivering the Better Childhood Programme and how these would be delivered. A copy of the presentation given to the Partnership outlining the development of the vision and how the programme would be delivered across Hartlepool through a 'locality model' is appended to the minutes of the meeting.

- AIM: The Better Childhood Programme is focussed on improving relationships across families and services to strengthen family resilience and reduce family breakdown.
- VISION: Our ambition as a children's partnership is to enable all children and families in Hartlepool to have opportunities to make the most of their life chances and be supported to be safe in their homes and communities.
- COLLECTIVE OBSESSIONS:
    1. Children and Young People have opportunities to make the most of their life chances and to be safe – *children are ready to learn and have opportunities to develop in and outside of school.*
    2. Improving family relationships, to reduce the number of children and families in need requiring a specialist worker.
    3. Reducing the impact of domestic violence, mental health, drugs and alcohol misuse on children and families.
    4. Helping parents, carers and young people to gain skills and get jobs.
- HOW WE WILL DELIVER THEM:
    - Support children and families to identify their needs and support requirements at the earliest opportunity;
    - Have a fully integrated workforce and approach to early intervention and support;
    - Focus on building effective relationships and stability of workers – parents with workers, children with workers and inter-professional relationships;
    - Support universal services and our wider workforce, to be confident and skilled in assessing and manage risk and delivering effective interventions to support families;
    - Child and parent voices are asked for, listened to and shape delivery of services; and

- Improve the definition, capturing and monitoring of outcome – evidencing impact.

There was concern expressed at the number of agencies involved with families and the need to avoid duplication particularly through governance. The Chair commented that there would be commonality through the shared aims but the various boards, this partnership and Health and Wellbeing Board for example, would have their own relevant aspects of the service delivery. The Assistant Director commented that some similarities would be expected; the focus would, however, be on outcomes. There were concerns raised that there were a number of boards (Health and Wellbeing Board, Hartlepool Safeguarding Children Board and the Strategic Partnership) and a meeting of the various chairs had been organised to discuss the programme. The Chair acknowledged that there would be differing roles across the partners and the role of the various Boards would be to ensure that the performance framework was being met.

A young people's representative highlighted the need to ensure that grandparents were included in the wider 'family' definition through the programme delivery as they provided a significant level of support in many families and were the primary carers of an increasing number of children and young people. The Assistant Director commented that grandparents were included in the wider definition of 'family' and acknowledged that where grandparents did play a significant role in a child's life then that needed to be recognised and supported appropriately.

The children and young people's representatives fed back their comments on the draft Better Childhood Programme proposals to the partnership. They commented -

- That some of the statements were too long; they needed to be shortened and simplified if young people were to understand the programme fully.
- Substance and alcohol misuse was seen by young people as being the major issue. There were also a growing number of young people 'vaping' as it was becoming an acceptable thing to do; health awareness needed to be improved.
- Mental health issues needed greater focus. The impact on families and children were not always recognised. The Youth Parliament had been looking at the issue of bullying and the mental health issues that it created. Interventions needed to be at the earliest possible stage and appropriate training and guidance needed to be given. It was highlighted that Manor College were looking at the potential of employing a full time counsellor.
- In terms of employment, young people's aspirations needed to be widened as they were often seeing school simply as a staging post for the next level of education. Too many also had the view that as there were no real opportunities in Hartlepool educational attainment didn't really matter. The young people's representatives considered that there need to be greater emphasis during secondary school on aspiration and

career development.

It was also questioned by the young people if the new approach would replace the social worker allocated to children with disabilities. The Assistant Director stated that if the child and/or the family needed a social worker allocated then that would continue. The aim would be to assess at as early an opportunity as possible what the needs of the individual and the family were and address those through the coordinated approach. It was hoped that by addressing issues at an early stage and building resilience within the family, this would be better for the family in the longer term.

The Assistant Director continued through the presentation to outline the process of reaching the proposals for a delivery model based around localities centred on the four Children's Centres (Chatham, Hindpool, Rossmere and Stranton). The approach based on a single lead worker for a family was welcomed by the Partnership members though the Chair commented that much depended on there being a stable workforce. Officers commented that there was a generally stable workforce, though there were things outside of management's control such as maternity/paternity leave and sickness. What could be controlled was minimising the changes in allocated workers to families and this could be assisted by giving lead workers the ability to bring in other specialised support as and when it was needed rather than referring the family onto to another service and another worker being allocated to take over.

The Assistant Director added that having lead workers with a wider range of skills and also with the ability to draw in specialised services as necessary should reduce the number of workers involved with a family and also help in addressing need much earlier. The case file reviews of looked after children showed that if different or quicker actions had been taken initially then the children may not have come into the looked after system.

The Voluntary and Community Sector representative questioned how the third sector would also be involved and the Assistant Director indicated that once the locality teams had been established there would then be a review of local providers.

The Chair commented that formal consultation with Trade Unions would need to be undertaken. The Assistant Director hoped that as this service redesign had been driven by staff, discussions with the Trade Unions should prove favourable.

The Chair questioned how the 'new' lead workers would be labelled; this could be important for some families. The Assistant Director commented that in many cases, the family were not particularly bothered where the worker came from and were more interested in it being someone they could relate to and someone who could give them the support they required. The focus would be around aligning the worker to the needs of the family. The wider the scope of 'universal' skills that lead workers had the better but there would be occasions when other professionals would need to be

brought in.

The Assistant Director responded to questions on how the effectiveness of the programme would be monitored by indicating that in the longer term a reduction of the numbers of children entering the Looked After system would be a major marker. There would be other evaluation criteria built in, with some being to be benchmarked against statistical neighbours.

The involvement of health services in the development of the locality teams was questioned. The Assistant Director indicated that initially discussions had been held with the Clinical Commissioning Group as service commissioners to gain that initial 'buy-in'.

The Chair asked the group to address the four key questions set out at the end of the presentation: -

1. Are CSP happy to proceed with the locality model proposed?
2. How can your organisation best support the implementation of these changes, and who is best placed to do this?
3. How can CSP best support and oversee multi-agency governance in each of our four proposed localities?
4. How can CSP best support/ facilitate the integration of other partner services with locality teams in the future?

The Chair sought the partnership's support to the locality model which was given without dissent. In addressing the second question, the Chair suggested that it may be appropriate for a recommendation go forward from this group to the Health and Wellbeing Board indicating this partnership's support for the locality model being proposed for the Better Childhood Programme and seeking their endorsement to the proposals as all the relevant 'chief officers' of the partner organisations were represented at the Board.

In relation to governance, The Assistant Director stated that a report would be brought to a future meeting so the partnership could discuss the arrangements and the appropriate devolution of some controls down to the localities. Further discussions would also be required on the integration of partners' services within the teams.

Following the conclusion of the discussion on the locality teams, the Assistant Director indicated that some work had been undertaken to review the CAF (Common Assessment Form) which seemed to be universally disliked. Martin Todd (Changing Futures NE) had undertaken some work on a new early help assessment, a draft of which was circulated to the group. It was indicated that there had been some staff workshops with council and other agency workers to review the CAF. There was some discussion as to whether the word 'assessment' was an issue in itself but it was felt that families were often quite comfortable with 'assessments' for various other services and benefits. Much would depend on the workers completing the form and undertaking that process in an open and

transparent way with the family. The Voluntary and Community Sector Representative commented that the form would also be used by other agencies such as WVARC.

It was acknowledged that the new assessment form would need to be fully adopted by all agencies and all staff appropriately trained. It would also need to be incorporated within the appropriate IT systems. Martin Todd indicated that some workers were taking the new form out on visits to families to gain some feedback; this would be fed back to the Partnership.

In closing the meeting, the Chair thanked all the representatives for their support and involvement in the development of the proposals discussed.

Decision

1. That the Children's Strategic Partnership supports the locality model for the delivery of the Better Childhood Programme as set out in the presentation to the meeting.
2. That further reports be submitted to the Partnership on the Early Help Assessment and the governance arrangements for the Better Childhood Programme.
3. That a recommendation be forwarded from this group to the Health and Wellbeing Board indicating this partnership's support for the locality model being proposed for the Better Childhood Programme and seeking the Board's and partner organisations endorsement to the proposals.

19. Any Other Items which the Chairman Considers are Urgent

There was no other business the Chair considered urgent. The meeting noted that the next meeting would be held on Tuesday 23 February 2016 at 4.15 pm.

The meeting concluded at 5.55 pm.

CHAIR

HEALTH AND WELLBEING BOARD

13th June 2016

Report of: Director of Public Health

Subject: REVIEW OF TERMS OF REFERENCE

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1. TYPE OF DECISION

1.1 Non key.

2. PURPOSE OF REPORT

2.1 The purpose of this report is to provide an opportunity for the Health & Wellbeing Board, to review their Terms of Reference for the Board, at the first meeting in the new municipal year.

3. AREAS FOR CONSIDERATION

3.1 The following areas have been identified for further discussion:

- Confirm the Board still commits to hosting one Face the Public Event a year as per the local authority constitution.
- Confirm that Board members can send substitutes to the Board, but this substitute should be named as the substitute. This person should be the only person to attend in the absence of the Board member.
- Confirm that the Board will hold an annual review meeting and reflect on the performance of the Board and proactively plan for the forthcoming year.
- Confirm that as the Health and Wellbeing Strategy is the responsibility of the Board to produce, that an action plan is agreed to implement the Strategy. It should be noted that previously the Terms of Reference required the Board to monitor progress through quarterly performance reporting. Is this still the intention of the Board to receive quarterly reports?
- The Terms of Reference described a supporting sub structure for the work of the Board. It is proposed that this sub structure is received, including the role and function of the Joint Commissioning Executive.
- Confirm that the minutes of the Children's Strategic Partnership are circulated to the Health and Wellbeing Board to ensure a link between both bodies.

- Note the removal of North Tees and Hartlepool NHS Foundation Trust from the Board as non voting members in the revised Terms of Reference.
- Note the Director of Regeneration and Neighbourhoods or named substitute will remain as a non voting member on the Board, but attendance will be determined by the requirements of the agenda.

4. RECOMMENDATIONS

4.1 It is recommended the Board members confirm agreement on items listed in 3.1.

4.2 It is recommended that the Board receive a report reviewing the sub structure supporting the Board by September 2016.

5. CONTACT OFFICER

5.1 Louise Wallace
Director of Public Health
Hartlepool Borough Council
4th Floor Civic Centre
Louise.wallace@hartlepool.gov.uk

HEALTH AND WELLBEING BOARD

13 June 2016

Report of: Dr Paul Williams

Subject: INTRODUCTION TO NEW GP FEDERATION

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1. PURPOSE OF REPORT

1.1 To introduce the Health and Wellbeing Board to Hartlepool and Stockton Health, the new organisation bringing together general practices in both local authority areas.

2. BACKGROUND

2.1 There are fifteen separate general practices in Hartlepool, each largely working independently to provide a range of services to patients. Similarly there are 23 separate practices in Stockton. Practices have come together to form a single organisation that can deliver services collaboratively. The leader of this new organization is Dr Paul Williams..

3. PROPOSALS

3.1 Dr Paul Williams, would like to introduce the organisation and talk about the potential for improving the quality and organisation of non-hospital care for local patients. He will be present to participate in a strategic discussion and answer questions as required.

4. RECOMMENDATIONS

4.1 For information and discussion only.

5. REASONS FOR RECOMMENDATIONS

5.1 This is of strategic importance to the Health and Wellbeing Board

6. BACKGROUND PAPERS

None

7. CONTACT OFFICER

Dr Paul Williams ceo.hash@gmail.com

HEALTH AND WELLBEING BOARD

13 June 2016

Report of: Ali Wilson, Chief Officer, NHS Hartlepool and Stockton-on-Tees CCG

Subject: SUSTAINABILITY AND TRANSFORMATION PLAN

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1. PURPOSE OF REPORT

1.1 To provide the Board with an update by presentation on the national planning process required to deliver the Five Year Forward View and to describe the local process for delivery.

2. BACKGROUND

2.1 In December 2015, the NHS published planning guidance 16/17 – 20/21 requiring the production of a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.
In January 2016 44 STP 'footprints' were agreed. The health and care organisations within these geographic footprints which are based on 'natural communities/patient flows' are expected to work together to develop STPs which will help drive genuine and sustainable transformation in patient experience and health outcomes of the longer-term.
The footprints are expected to take account of the scale needed to deliver the transformation of services and public health programmes required deliver against the prevention gap, the care and quality gap and the financial gap identified in the Five year forward view.

3. PROPOSALS

The presentation will provide further information on the local arrangements for delivery of the plan.

5. RECOMMENDATIONS

5.1 The Health and well Being Board are requested to receive the presentation and comment on how they would like to be involved and informed as this work progresses.

6. REASONS FOR RECOMMENDATIONS

The local Hartlepool Plan will define and focus on addressing local needs however the STP will need to reflect both local plans and those areas that can only be addressed at a larger footprint level. Proposals for approval of the final plan is as yet unclear.

7. BACKGROUND PAPERS

8. CONTACT OFFICER

Ali Wilson,

HEALTH AND WELLBEING BOARD

13 June 2016

Report of: Director of Public Health

Subject: ASSISTED REPRODUCTIVE UNIT AT THE UNIVERSITY OF HARTLEPOOL HOSPITAL - UPDATE

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1. PURPOSE OF REPORT

1.1 To update the Health and Wellbeing Board on the public consultation in relation to the future location of assisted reproduction services.

2. BACKGROUND

2.1 The decision taken by the North Tees and Hartlepool Foundation Trust to close the Assisted Reproduction Unit (ARU) at the University Hospital of Hartlepool, with effect from the 31st March 2016, resulted in the initiation of legal action by Hartlepool Borough Council. This resulted in a Consent Order, agreed by the High Court on the 5th April 2016, which required that the North Tees and Hartlepool Foundation Trust:

- Engage with users around the future of the licensed fertility treatment at the ARU and consult with the Hartlepool Borough Council (HBC) individually and/or a joint committee with Stockton-on-Tees Borough Council and Durham County Council as to the proposals.

- Take no steps to facilitate the closure of the ARU and, to its best endeavours, continue the provision of licensed treatment services until the conclusion of the consultation and a decision has been made; and

- Uses its best endeavours, alongside Hartlepool Borough Council and the Hartlepool and Stockton Clinical Commissioning Group (CCG), to ensure that consultation and engagement is completed and a final decision taken, by 31 July 2016.

2.2 In taking the issue forward within the prescribed timescale, the CCG requested the establishment of an independent Clinical Review Team through the Northern Clinical Senate. This team, in consultation with the CCG and taking into consideration the factors outlined below, developed a number of service options for the future delivery of ARU services.

- HFEA licence requirements;
- Continuity in provision for patients;
- Travel times to alternative provision; and
- Alternative provision by other providers and their ability to increase capacity should this be required.

2.3 A formal consultation on the identified options (as detailed in Table 1) commenced on the 31 May 2016 and will continue until the 15 July 2016, with local people are being invited to provide their views, experiences and ideas about assisted reproduction services in Hartlepool. A full overview of the consultation is available at: **www.haveasay.org.uk**

Table 1

Service Option
1: A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision remains at Hartlepool delivered by an alternative provider.
2: Unlicensed assisted reproductive services continue to be delivered at Hartlepool and patients requiring licenced provision choose to go to an alternative site e.g. James Cook University Hospital, Queen Elizabeth University Hospital, Gateshead and Newcastle Fertility Centre at the Centre for Life.
3: A comprehensive assisted reproductive service including HFEA Licensed and unlicensed provision will no longer be available at Hartlepool but will be delivered at other sites in the region.

2.4 All of the feedback gathered during the consultation process will be collated by an independent data analyst using the information, and views, to decide how best to proceed with the future structure of assisted reproduction services in Hartlepool. This will be considered within the clinical evidence base, health policy, staffing and financial resources.

3. NEXT STAGES

3.1 The next steps are outlined in **Table 2** over the page.

Table 2

31 May 2016	Consultation period opens online and collateral will be delivered to GP practices, the service at Hartlepool Hospital and other local venues such as libraries
07 Jun 2016	Clinical Senate to visit Hartlepool site to meet with key stakeholders
w/c 20 June 2016	Clinical senate report to be published on website
30 June 2016	Overview and Scrutiny - Update
15 July 2016	Consultation period closes
25 July 2016	Report produced
26 July 2016	CCG Governing Body
28 July 2016	Overview and Scrutiny
31 July 2016	Report published

4. RECOMMENDATIONS

4.1 That the report be noted.

5. REASONS FOR RECOMMENDATIONS

5.1 The issue is of significant local importance to service users and residents.

6. BACKGROUND PAPERS

None

7. CONTACT OFFICER

Joan Stevens – Scrutiny Manager
Chief Executive's Department – Legal Services
Hartlepool Borough Council
Tel: 01429 284142
Email: joan.stevens@hartlepool.gov.uk

HEALTH AND WELLBEING BOARD

13 June 2016

Report of: Director of Child & Adult Services

Subject: Better Care Fund: 2015/16 Q4 Return

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1. PURPOSE OF REPORT

1.1 To present to the Health and Wellbeing Board the 2015/16 Q4 BCF return.

2. BACKGROUND

2.1 The Better Care Fund 2015/16 had six National Conditions that needed to be met in order for the pooled money to be accessed. These were:

- Plans to be jointly agreed (by Councils and CCGs, with engagement of providers and sign off by the Health & Wellbeing Board).
- Protection for social care services (not social care spending).
- Provision of seven day services in health and social care to support hospital discharges and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care using the NHS number.
- A joint approach to assessments and care planning with an accountable professional for integrated packages of care.
- Agreement on the impact of changes in the acute sector.

2.2 There were five national performance measures associated with the BCF:

- Permanent admissions of older people (aged 65 and over) to residential and nursing homes.
- Proportion of older people (aged 65 and over) who are still at home 91 days after discharge from hospital to reablement / rehabilitation services.
- Delayed transfers of care from hospital.
- Avoidable emergency admissions to hospital.
- A measure of patient / service user experience.

2.3 BCF plans were also required to include one locally determined performance measure. The agreed local measure for Hartlepool is the estimated diagnosis rate for people with dementia.

2.4 BCF plans were required to demonstrate achievement of the national conditions, and to set targets to improve performance against the national and locally determined measures. Performance against these conditions and targets was monitored nationally by NHS England.

3. BCF Q4 RETURN & PERFORMANCE DATA

3.1 BCF performance reports have been submitted to NHS England on a quarterly basis throughout 2015/16. The deadline for submission of the Q4 return (covering the period January – March 2016) was 27 May 2016.

3.2 The 2015/16 Q4 return is attached at **Appendix 1** and indicates that all national conditions are being achieved.

3.3 In relation to performance measures:

Permanent Admissions to Residential and Nursing Care Homes
The target for 2015/16 has been achieved, with the number of admissions significantly reduced when compared to the previous twelve months. This reduction is partly attributable to the range of alternatives to residential care that have been developed over recent years and which are now supported, or have been further enhanced, through the Better Care Fund. These services include low level support, telecare, reablement, extra care and housing related support, as well as support for carers to maintain their caring role.

It should be noted though, that the reduction achieved has also been affected by the fact that there were an unusually high number of admissions to residential care in 2015/16 of people who fund their own care and do not receive support from the Council. This factor is very volatile and it is not possible to forecast with accuracy the proportion of admissions of this nature in future years.

On this basis the target set for 2016/17 is challenging, in that it represents a further reduction when compared to the 2015/16 target, but realistic in that no assumption has been made that the unusually high proportion of people who fund their own care will be replicated in 2016/17.

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

Proportion of older people still at home 91 days after discharge from hospital into reablement / rehabilitation services
Current data indicates that the target for 2015/16 will not be met, although performance is expected to be good with approximately 83% of people still at home 91 days after discharge from hospital into reablement / rehabilitation services. It is recognised that, on reflection, the target of 89.2% was very challenging and potentially unrealistic in the context of the very complex needs of many people who are discharged from hospital into these services.

It should be noted that this measure of how effective reablement services are only considers a subset of the people who access reablement services, with many people accessing the service from the community as a preventative measure. Local measures indicate that 427 reablement packages were started in the first 9 months of 2015/16 with 79% of people having no ongoing social care needs following provision of a completed reablement package and 92% of reablement goals achieved at the end of a period of reablement.

The target set for 2016/17 demonstrates ambition to improve on performance in 2015/16, while also being realistic about what is achievable.

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

This target was achieved in Q1, but there has been an increase in days delayed due to DTOCs in Q2, 3 and 4. The planned target for Q4 of 547.8 days has not been achieved and actual performance was 991.4. As a result of these increases, the annual rate is 22% higher than the target set within the plan. However, there has been an overall 9.68% reduction in the number of delayed days from 2014/15 to 2015/16.

The Trust Choice Policy has been revised and this, alongside on-going work with care homes is expected to have a further positive impact and reduce the number of delayed transfers. Quarterly progress updates will be provided to the DToC Steering Group which has been established to deliver the 2016/17 BCF DToC requirements through improved integrated working.

Total non-elective admissions into hospital per 100,000 population

Year end performance data indicates that non elective admissions have reduced by 0.1% when comparing 2015/16 performance with 2014/15. When comparing the last quarter (January – March) there has been an increase of 11.24% in the number of non-elective admissions in 2015/16 and this has dramatically reduced the annual reduction from the previously reported 5.03%. This measure will continue to monitored closely throughout 2016/17.

Estimated diagnosis rate for people with dementia

Using the criteria agreed by the Better Care Support team this indicator continues to be comfortably achieved. The target for 2015/16 was 69.01% with an actual 76.47% being achieved.

3.4 Local performance indicators are also used to evidence impact of the BCF.

Use of Assistive Technology

Investment in assistive technology has enabled the number of people receiving support to grow on an annual basis for the last five years with over 2,000 people now using assistive technology. Investment in different forms of technology has enabled the service to support a wide range of people including adults with learning and physical disabilities and people with dementia, as well as being available to all over 75s and a feature of extra care schemes. Feedback from people accessing the service is positive, and the service is an essential part of the wider strategy to support people to stay

independent in their own homes for as long as possible. BCF funding has been identified to sustain and further expand the service, which will include exploring how telehealth can be better utilised.

Time Period	Number of clients accessing assistive technology
2012/13	1,102
2013/14	1,615
2014/15	1,970
2015/16	2,010

Support for Carers

It is recognised that carer breakdown can be a factor in hospital admissions and care home admissions, and evidence suggests that providing carers with support enables them to continue in their caring role for longer, preventing the need for more intensive and costly health and social care interventions. BCF funding is used to fund carers support services, including Direct Payments that provide carers with a break from their caring role.

Time Period	Proportion of carers receiving assessment / information & advice / carers services
2012/13	40.1%
2013/14	65.1%
2014/15	64.3%
2015/16	85.4%

The table below identifies the proportion of carers being supported by a Direct Payment (this indicator was introduced in the Adult Social Care Outcomes Framework in 2014/15 so data is not available prior to that date).

Time Period	Proportion of carers receiving a Direct Payment
2014/15	65.3%
2015/16	61.9%

Effectiveness of Re-ablement Services

Regional measures have been developed to measure the effectiveness of re-ablement services, including a measure of the proportion of re-ablement goals achieved at the end of a period of re-ablement.

Time Period	Proportion of reablement goals achieved at the end of a period of reablement
2014/15	87%
2015/16	91.5%

Overall satisfaction of people who use service with their care and support

The recent annual national survey of people who use adult social care services demonstrates that overall satisfaction of people using adult social care in Hartlepool has increased.

Time Period	Overall satisfaction of people who use service with their care and support
2014/15	64.6%
2015/16	67.9%

4. IMPACT OF BCF IN 2015/16

4.1 As part of the development of BCF plans for 2016/17, a review was undertaken of the impact of the BCF during 2015/16. This identified key achievements which are summarised in **Appendix 2**.

4.2 Plans for 2016/17 aim to build on these achievements, with a particular focus on admission prevention and closer working with primary care, and are summarised in **Appendix 3**.

5. RISK IMPLICATIONS

5.1 A risk register was completed as part of the original BCF plan with mitigating actions identified and this was updated for the 2016/17 plan.

6. FINANCIAL CONSIDERATIONS

6.1 The BCF Pooled Budget is hosted by Hartlepool Borough Council and governed through the Pooled Budget Partnership Board.

6.2 It was a requirement that 2015/16 BCF Plans included an element of funding for 'Payment by Performance'. This funding was released based on quarterly performance in terms of reducing non elective hospital admissions. Based on performance data for non elective admissions, the Q4 element of this funding was released and used to support implementation of the BCF plan.

6.3 The BCF Pooled Budget was fully committed in 2015/16 with slippage used to support one off pressures in adult social care and Disabled Facilities Grants.

6.4 Plans have been agreed that fully commit the budget for 2016/17 and the budget will continue to be monitored throughout the year through the Pooled Budget Partnership Board.

7. LEGAL CONSIDERATIONS

7.1 The legal framework for the pooled budget is a Section 75 Partnership Agreement. Section 75 of the National Health Service Act 2006 gives powers to local authorities and CCGs to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority and NHS functions.

7.2 A Section 75 Partnership Agreement was in place for 2015/16 and a new agreement is currently being finalised for 2016/17, in line with the national requirement to have this in place by 30 June 2016.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 None identified.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 None identified.

10. STAFF CONSIDERATIONS

10.1 No staff considerations identified.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 No asset management considerations identified.

12. RECOMMENDATION

12.1 It is recommended that the Health and Wellbeing Board notes the 2015/16 Q4 return, which was submitted on behalf of the Health and Wellbeing Board using delegated authorities as previously agreed.

13. REASONS FOR RECOMMENDATION

13.1 It is a requirement that Health & Wellbeing Boards approve plans and performance reports in relation to the BCF.

14. CONTACT OFFICER

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Cover

Q4 2015/16	
Health and Well Being Board	**Hartlepool**
completed by:	Jill Harrison
E-Mail:	jill.harrison@hartlepool.gov.uk
Contact Number:	01429 523911
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Christopher Akers-Belcher (Chair)

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	16
4. I&E	19
5. Non-Elective Admissions	2
6. Supporting Metrics	9
7. Year End Feedback	16
8. New Integration Metrics	67
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Hartlepool

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Hartlepool

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	Yes	Yes	Yes	
4) In respect of data sharing - please confirm:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes	Yes	
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	No - In Progress	No - In Progress	No - In Progress	Yes	Yes	
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	No - In Progress	No - In Progress	Yes	Yes	
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes	Yes	Yes	

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

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

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Hartlepool

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,208,000	£1,942,000	£1,663,000	£1,663,000	£7,476,000	£7,476,000
	Forecast	£1,646,000	£1,379,000	£1,710,000	£2,741,000	£7,476,000	
	Actual*	£1,646,000	£1,379,000	£1,710,000			

Q4 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£2,208,000	£1,942,000	£1,663,000	£1,663,000	£7,476,000	£7,476,000
	Forecast	£1,646,000	£1,379,000	£1,710,000	£2,741,000	£7,476,000	
	Actual*	£1,646,000	£1,379,000	£1,710,000	£2,741,000	£7,476,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£1,869,000	£1,869,000	£1,869,000	£1,869,000	£7,476,000	£7,476,000
	Forecast	£1,195,000	£1,684,000	£2,253,000	£2,344,000	£7,476,000	
	Actual*	£1,195,000	£1,684,000	£2,253,000			

Q4 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£1,869,000	£1,869,000	£1,869,000	£1,869,000	£7,476,000	£7,476,000
	Forecast	£1,195,000	£1,684,000	£2,253,000	£2,344,000	£7,476,000	
	Actual*	£1,195,000	£1,684,000	£2,253,000	£2,344,000	£7,476,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	

Commentary on progress against financial plan:	Q4 spend includes an element of DFG capital expenditure fully committed where works did not commence in 2015/16.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

Non-Elective Admissions

Selected Health and Well Being Board: Hartlepool

	Baseline				Plan					Actual				
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring. Please insert into Cell P8	2,349	2,372	2,358	2,496	2,409	2,241	2,227	2,362	2,318	2,318	2,252	2,299	2,236	2,579

Please provide comments around your full year NEA performance	North Tees and Hartlepool NHS FT have implemented a new patient access system in October 2015. This change in system has created some issues with MAR submissions and the Trust have had to resubmit data within quarter 3. The figure for quarter 3 should now be 2,417. Based on the updated figures this gives a total number of emergency admissions for 2015/16 of 9,547, which is a reduction of 0.1% on 14/15 emergency admissions.

Footnotes:

##

National and locally defined metrics

Selected Health and Well Being Board:	Hartlepool

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The significant reduction achieved in 2015/16 is partly attributable to alternatives to residential care that have been developed over a number of years including low level services, telecare, extra care and housing related support, but also in part attributable to the unusually high proportion of admissions to care homes in 2015/16 that were for people who funded their own care.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	There has been a slight reduction in the percentage of people still at home 91 days after discharge from hospital to reablement / rehabilitation services. This is a subset of all people accessing reablement services and local measures indicate that reablement is working effectively with over 90% of reablement goals acheived and over 70% of people requiring no ongoing support following a period of reablement.

Local performance metric as described in your approved BCF plan / Q1 / Q2 / Q3 return	Estimated diagnosis rate for people with Dementia (NHS Outcomes Framework 2.6.i)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	This indicator continues to be comfortably achieved.

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	Aggregate of 3 Measures (percentage): Measure 1 - ASCOF 3A: Overall satisfaction of people who use services with their care and support. Measure 2 - ASCOF 3B: Overall satisfaction of carers with social services. Measure 3 - Percentage of patients responding 'very good' or 'fairly good' out of the total patients responding to
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Some of the data required for this measure is collected bi-annually. This metric is being reported using the most up to date data available.

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Year End Feedback on the Better Care Fund in 2015-16

Selected Health and Well Being Board:	Hartlepool

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. Our BCF schemes were implemented as planned in 2015-16	Agree	
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Agree	
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Agree	
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Agree	
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Neither agree nor disagree	
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Agree	
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Agree	
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Neither agree nor disagree	
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Neither agree nor disagree	
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Agree	

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

11. What have been your greatest **successes** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **successes**	Response category:
Success 1	Establishment of the Early Intervention Model - detail in narrative in Section 9.	2.Delivering excellent on the ground care centred around the individual
Success 2	Development of Hartlepool Now and low level sevrices that support people to maintain their independence - deatil in narrative in Section 9.	2.Delivering excellent on the ground care centred around the individual
Success 3	Improved support for people living with dementia and their families - detail in narrative in Section 9.	2.Delivering excellent on the ground care centred around the individual

12. What have been your greatest **challenges** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Moving towards shared records that further improve person centred care and support preventative approaches.	3.Developing underpinning integrated datasets and information systems
Challenge 2	Identifying the specific impact of the BCF, given that it is part of the wider health and social care integration agenda and has some metrics that cover all ages while BCF investment locally has been targeted largely at older people.	5.Measuring success
Challenge 3	We haven't yet got a solution for psuedonomised data. We are working closely with the CSU to develop a solution to meet our needs.	3.Developing underpinning integrated datasets and information systems

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

New Integration Metrics

Selected Health and Well Being Board: Hartlepool

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Shared via interim solution
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Mental Health	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Shared via interim solution
From Specialised Palliative	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Shared via interim solution	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/05/16	01/04/17	01/04/17	01/04/17	01/04/17	01/04/17

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot commissioned and planning in progress

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	42
Rate per 100,000 population	45

Number of new PHBs put in place during the quarter	5
Number of existing PHBs stopped during the quarter	13
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	52%

Population (Mid 2016)	93,172

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	No - nowhere in the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html
Q4 15/16 population figure has been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Hartlepool

Remaining Characters	12,326

Please provide a brief narrative on year-end overall progress, reflecting on the first full year of the BCF. Please also make reference to performance on any metrics that are not directly reported on within this template (i.e. DTOCs).

The BCF plan was jointly developed and common aims were agreed:

• To ensure that the population of Hartlepool have 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.

Three key themes were identified within the plan
• Low Level Services & Self Management of Long Term Conditions
• Intermediate Care
• Improved Dementia PathwaysProgress has been summarised against each of these three themes:

BCF ACHIEVEMENTS – 2015/16

(Extract from BCF Plan for 2016/17)

Three key themes were identified within the BCF plan

- Low Level Services & Self Management of Long Term Conditions
- Intermediate Care
- Improved Dementia Pathways

Progress has been summarised against each of these three themes:

Theme 1: Low Level Services & Self Management of Long Term Condition

Low level services aim to support people to maximise their own financial, human and community resources to achieve self-determination. People are supported to access resources in their own communities and to manage their own conditions and statutory agencies are committed to working with the voluntary and community sector to ensure that those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. Through the development of the BCF plan partners committed to invest in empowering local people through effective facilitation and signposting, carers support, self-management and low level preventative services to maximise their independence and wellbeing and to help identify and combat social isolation, as a major influence on overall health and wellbeing. Work has also been undertaken with public health colleagues to review opportunities to further support and target people with a range of long term conditions in the community and / or their own homes, building upon the success of existing programmes commissioned by public health (such as Health Trainers and the Falls Service) whilst developing a more preventative, proactive and targeted approach.

Achievements in 2015/16 include:

Hartlepool Now

Hartlepool Now has been developed as on online system to support people who need advice and information and want to know about services in their local area. The site was formally launched in October 2015 and is focused on supporting people to maintain their independence. There are includes eight main categories: Living at Home; Looking After Someone; Housing Options and Care Homes; Keeping Safe; Getting Out and About and Socialising; Keeping Healthy; Working and Learning and Money Matters, and is designed to allow people to find information that meets their specific needs. The site also features the Equipment Finder which enables people to find pieces of equipment that can help them in their day-to-day living and tasks and, if they want to, click on and buy the equipment they need.

Assistive Technology

Investment in assistive technology in Hartlepool has enabled the number of people receiving support to grow on an annual basis for the last five years with over 2,200 people using assistive technology at the end of December 2015. Investment in different forms of technology has enabled the service to support a wide range of people including adults with learning and physical disabilities and people with dementia, as well as being available to all over 75s and a feature of extra care

schemes. Feedback from people accessing the service is positive, and the service is an essential part of the wider strategy to support people to stay independent in their own homes for as long as possible. BCF funding has sustained and further expanded the service, which includes exploring how telehealth can be better utilised.

Support for Carers

It is recognised that carer breakdown can be a factor in hospital admissions and care home admissions, and evidence suggests that providing carers with support enables them to continue in their caring role for longer, preventing the need for more intensive and costly health and social care interventions. BCF funding is used to fund carers support services, including Direct Payments that provide carers with a break from their caring role.

Approximately 65% of carers in Hartlepool receive an assessment, information and advice or a carers service and, of those carers receiving support, 75% received this via a Direct Payment (as at end of December 2015).

Low Level Services

Low level support services for older people have been re-commissioned to provide a range of social inclusion services through one provider, encompassing information and advice, low level support, luncheon clubs (and luncheon club plus) and social inclusion opportunities within a building based setting. The service is called Hartlepool Getting Out and About.

Information & Advice - The provider has developed a bank of essential information for older people in the community (made available on paper and electronically so it can be accessed easily). The service gathers information on local activities, classes and community and interest groups and all information is uploaded to Hartlepool Now.

This service can be provided by sitting alongside people and using the information gathered and held on directories and electronic devices to find the information/ service they require. If the person needs help to understand the information, time is allocated by staff to enable the person to do this. If specialist help is needed to further explain the information all avenues will be pursued to obtain this support. This will include signposting to advocacy services and volunteers if available.

Low Level Support - provided for individuals with low level needs on a one to one basis for a period of up to 6 weeks, aiming to promote independence and enable people to get on with their lives. This may include:

- Telephone calls to enquire after someone's well being;
- Assisted visits to community groups, activities and other locations in order to build people's confidence; facilitate connections to social/educational and other activities; and encourage them to get out and about;
- Support to get to important appointments e.g. during a period after someone has had a fall and is lacks confidence going out and about on their own; and
- Assistance to do one or two shopping visits and information and encouragement after that to encourage individuals to arrange long term solutions for getting their shopping if the need for support is going to continue.

Luncheon Clubs (Plus) –operate in a variety of settings, for example pubs and community centres, throughout the town. Lunch club sessions will be held for up to three hours and will provide an opportunity for people to buy lunch and enjoy an informal social atmosphere.

A range of activities such as gentle exercise classes, wellbeing sessions, guest speakers and handicrafts are provided alongside the actual luncheon club, making use of nearby community resources. Information and sign posting will also be provided through assistance to access the internet, leaflets etc and staff will assist with arranging transport for people who use the service.

The current service facilitates luncheon clubs in 5 venues, supporting approximately 70 people. For people who require help with eating or accessing the toilet the service will provide Luncheon Club Plus. These sessions operate in the same way as the luncheon clubs identified above but have a higher staffing ratio and can support people who are less able, but wish to remain in their local community.

Social Inclusion – this centre based element of the service is available for frail elderly people for whom other elements of the service identified above would not be suitable to meet their needs. This service is provided at Hartfields Day Centre from 10am to 3pm Monday to Friday and complemented by a luncheon club plus session on a Saturday.

The service provides stimulating activities such as gentle exercise classes, wellbeing sessions, visits to places of interest, guest speakers, gardening, films and drama, handicrafts etc. Information and sign posting is also provided through assistance to access the internet, leaflets etc. The current service includes a meal and transport is also arranged and provided.

The overall service model helps people to overcome barriers to accessing activities and resources for the first time; provides continued support until people feel able to continue to access independently and promotes continued engagement and attendance.

Theme 2: Intermediate Care

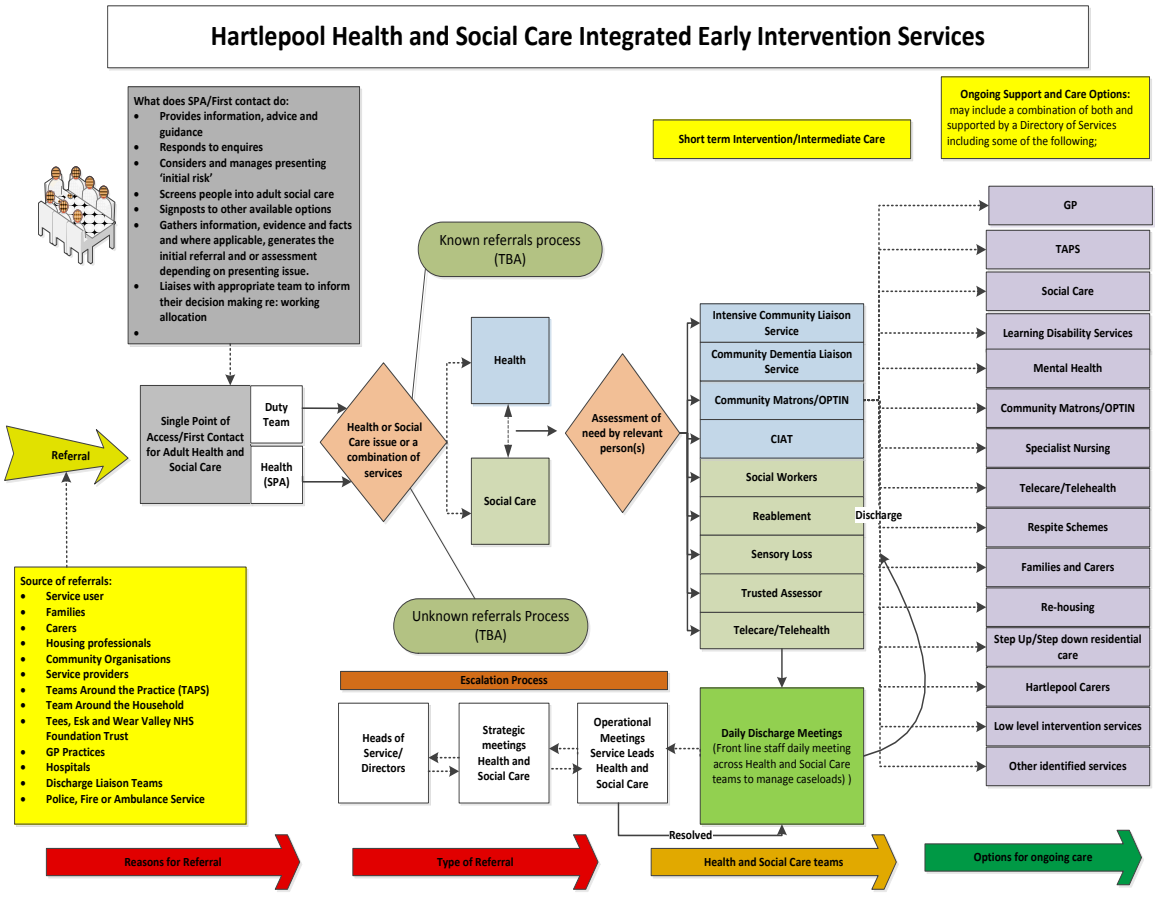
The vision for an Integrated Health and Social Care Early Intervention Model is ambitious, however partners are committed to developing a culture in which public bodies are able to work together with their partners in the voluntary and social enterprise sectors and remove unhelpful boundaries using combines resources to achieve the maximum benefit for service users, carers and families.

The Better Care Fund project team continues to build upon the work undertaken in 2015/16 in relation to co-location and integration of services. The aim and ambition of the service model is to provide a single point of access for every person with whom health and social care engage in order to facilitate the most appropriate health and social care response based on presenting need both in and out of hours.

The service model focuses on all people known and unknown to community nursing and social care services to identify those at higher risk of requiring intervention.

People will experience an integrated service which is flexible and responsive enough to recognise the different needs of individuals shifting from reactive (unplanned) care to prevention and proactive care. Critical to the success of the Integrated Model in 2016/17 will be the interface and relationship with primary care partners (General Practice) to develop services that are wrapped around the person with:

- Less dependency on intensive acute services due to earlier and targeted intervention.
- Fewer avoidable acute episodes through better management of conditions in the community, reducing unnecessary hospital and residential/nursing care admissions
- A reduction in emergency bed days associated with repeat acute admissions by more timely and co-ordinated intervention.
- Reduced duplication, inefficiency and waste at the interface of care.
- Reorganisation of pathways and removal of professional boundaries.
- Health and social care delivered in a more co-ordinated, efficient and cohesive way.
- People and families / carers knowing their individual pathway and having greater confidence in service delivery.



Achievements to date include:

- Adult services first contact team are co-located with the NHS Single Point of Access (SPA) in the first step towards an integrated health and social care single point of access. Further work is underway to establish how these teams work more cohesively and how capacity is enhanced, including a proposal for clinical input to SPA.
- Introduction of a clinical triage function within the SPA.
- A weekend working pilot from October 2015 – March 2016 which saw Social Workers are available from 10.00-4.00 during weekends and bank holidays, focused on facilitating hospital discharges. This was supported by additional weekend capacity commissioned from independent home care providers for the same period using system resilience funding.
- Establishment of Daily Discharge Planning Meetings which bring together professionals from a range of disciplines (such as nurses, social workers and therapists) to discuss every person requiring discharge from either social care, community services, direct care and support, acute beds or reablement/rehabilitation. This allows for joined up planning to take place, to ensure that the right professionals are working with the right person in the most effective way.
- Development of enhanced pharmacy support for care homes and domiciliary care providers.

Theme 3: Improved Dementia Pathways

People living with dementia and their carers should be able to access the same range and quality of services as the general population and new service developments should be dementia friendly and easily accessible by people with dementia and their carers. The learning from the North of Tees Dementia Collaborative continues to be used to inform the direction of travel, and to ensure that improvements are made and sustained.

Achievements to date include:

Dementia Advisory Service

The aim of the Dementia Advisory Service is to empower people who are affected by and/or suffering from dementia to be able to “live well with dementia”. The service complements health and social care services provided to people living with dementia and their carers by providing named contacts and a single point of access for the provision of information and support about dementia and the range of services, activities and benefits available in Hartlepool.

The service is reactive to the needs of the person with dementia, especially those who are newly diagnosed. Information, advice and support are offered at a pace and at a time that the person with dementia and their carer can cope with. This includes responding to changing needs as the condition develops.

A key function is enabling the person with dementia and their carer to ‘re-narrate their lives;’ (redefining what is important to them going forward) so they can live fulfilling and worthwhile, if sometimes different, lives.

The service operates from a town centre based premises to provide a focal point giving independence and visibility to the service and offers:

- Accurate, timely and accessible advice to people with dementia and people who are affected by their dementia both on a person to person basis and a peer group basis, using social media.
- Opportunities for people with dementia for professional and peer support.
- A service that is practically accessible to residents within the borough of Hartlepool using the town centre base and utilising outstations as necessary or at home.
- Links to other statutory and voluntary agencies in order to ensure that there are clear and effective protocols for referring into and out of the service and working together.
- Development of best practice in the delivery of the service and to learn from best practice in other dementia advice services.
- A lead role in projects in Hartlepool designed to raise awareness of dementia and take away the stigma and fear that sometimes surrounds it.
- Responds to referrals within 24 hours or the next working day.
- Establishment of dementia peer support groups including a young onset support groups if needed. Groups may be centred on particular activities such as crafts or cooking or local history where the activity is a means by which people are able to engage with and support each other. They may be discussion groups about living with dementia where ideas and experiences can be exchanged. Access may be facilitated via existing structured networks e.g. memory cafe's, social events.
- Raises awareness of the advisory service amongst health and social care professionals in Hartlepool as well as the private and voluntary sectors.
- Provision of person to person information from the local hub and a variety of locations in Hartlepool as a stepping stone into a wider network of services. This advice will be given in a friendly, relaxed and non-judgemental manner in terms that people can understand.
- A stand-alone website dedicated to the Dementia Advisory Service but which will contain appropriate links to health and social care organisations and support networks or pathways commensurate with dementia support initiatives.

Access to the Service is on an open-access basis and referrals are monitored jointly by the Council and the Provider.

Dementia Friendly Hartlepool

The Working to Build a Dementia Friendly Hartlepool project has been successful in gaining the first level of accreditation which enables all interested parties that pledge their support to be able to register as part of the Dementia Friendly Community. This enables the wider community to have confidence that they will meet individuals and staff that are sensitive to the issues facing those living with dementia.

Following the success of gaining Dementia Friendly Community accreditation the official launch was celebrated by holding a Memory Walk in September 2015 at a local park. Over 100 people attended the event from the very young to residents of local residential homes. The event showed how successful awareness raising has been in the town and it is intended this will become an annual event.

There have also been significant levels of work carried out within residential homes to ensure that those living with dementia are cared for in the most appropriate way. This has built on the Care Homes project carried out through the Dementia Collaborative which delivered specific training to care home staff. Individuals now have an 'All About Me' folder which can be taken with them should they need to be admitted to hospital. This folder contains key information which enable those who do not know the individual to gain an insight to how dementia affects them and how best to manage the impact.

The Bridge

Early in 2015 The Bridge was opened in the town centre. The centre is a drop in and information centre for those living with dementia and their carers. The centre hosts the Dementia Advisory Service commissioned by Adult Services to ensure that anyone needing advice and support to navigate through previously unknown territory can do so in a positive and supportive place. The Bridge and Dementia Advisory Service are provided by the Hospital of God.

The Bridge has become a focal point for people, carers and professionals within the community. As well as providing professional services it is a community hub where people meet and small events are held, such as visiting musical artists and reminiscence sessions.

BCF PLANS – 2016/17

(*Extract from BCF Plan for 2016/17)*

Plans for 2016/17 build on what has been achieved in 2016/17 and aim to further integrate services across health and social care, as well as strengthening links with primary care and increasing the focus on prevention of avoidable admissions.

Priorities for 2016/17 have been identified as follows:

Enhancement of Early Intervention Model (EIM)

The current Early Intervention Model will be further enhanced from April 2016 with an increased focus on prevention of hospital / care home admissions through proactive partnership working between health and social care services. These new pathways of care will ensure service users are supported in the right setting, by the right service at the right time.

Throughout 2016/17 the BCF Project Team including commissioners and stakeholders will work to develop admission avoidance pathways wrapped around GP practices linked to the 2% Direct Enhanced Service (DES) and frailty registers. This model will involve 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.

This new model will support 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. It is envisaged that these meetings will also identify who is the most appropriate professional to support the individual from a care co-ordination perspective.

Implementation of 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 Falls Prevention Service commissioned by Public Health has been remodelled and is now provided by Hartlepool Borough Council as part of the wider prevention focused Early Intervention Model.

A dedicated team, co-located with the Single Point of Access for NHS Community Services, will undertake screening of all people identified as being at risk of a fall, with the aim of intervening early and preventing avoidable hospital admissions. As the service develops, it is intended that every person known to social care has a falls prevention plan, along with anyone known to health services that would benefit from a falls prevention plan being in place. The service will also support those who have had a fall and may be at risk of future falls.

The service will offer proactive education and training to professionals within the community who are likely to refer into the service, providing information, advice and guidance with the aim of limiting the number of older people requiring a hospital admission post fall and supporting professionals, where appropriate, to provide interventions themselves without the need for another professional team to become involved, which reduces duplication.

The Falls Prevention Service will work closely with the low level services commissioned through the BCF to ensure that interventions take into account identification and reduction of falls risks, for example through links with the Handyperson Service, and will also work closely with residential care homes to ensure staff have the key skills required to reduce risk of falls in care home settings.

Information about the service is available through is Hartlepool Now and a self assessment tool is being developed to allow people to generate their own falls prevention plans where they are able to do so.

Within the 2015/16 BCF plan the need to grow and expand the Telecare service was identified and use of assistive technology remains a key tool in keeping people at home safely with reduced likelihood of hospital or care home admissions. The Falls Prevention Service has been closely aligned to the Telecare service ensuring that access to a free assistive technology service is offered as part of the falls prevention plan.

The Falls Prevention Service also offers 6 week falls prevention clinics for members of the public, providing information and advice on reducing the likelihood of a fall, along with exercise based intervention to improve functional ability and core stability.

<u>Work with Cleveland Fire Brigade</u>
Work is underway with Cleveland Fire Brigade to understand how their contacts with older people in the community can be maximised. The Fire Brigade has a rolling programme of Fire Safety Checks for older people that are targeted initially at areas of deprivation and will be rolled out across all areas over time.

Close working relationships between the Fire Brigade and Adult Services have developed over a number of years with well established systems in place for the Fire Brigade to raise safeguarding alerts and tackle issues of fuel poverty and winter warmth, and it has recently been identified that there are further opportunities for joint working. Fire Safety Checks provide a real opportunity for information to be gathered and shared with other statutory services that will support older people to stay safe, well and independent in their own homes as well as being a way of reaching out to older people to provide them with advice and information.

A range of issues have been identified which will be built in to a low level assessment / checklist that the Fire Brigade will complete with an individual. This includes:

- Identifying older people who are socially isolated or lonely, who can then be signposted to services such as social activities, befriending or luncheon clubs.
- Basic screening questions in relation to meal preparation, shopping and weight loss that could identify is a person is at risk of nutritional decline.

- Basic screening questions in relation to financial worries which could lead to signposting to maximise benefits.
- Identifying environmental issues that could lead to falls risks, such as poor lighting and loose carpets which can be addressed by the Handyperson Service.
- Highlighting housing issues that may include an inability to maintain the property or hoarding issues which could result in the person being supported to better understand the range of housing options available.

In addition to gathering information, the Fire Brigade will be able to signpost people to support available in their community through use of the Hartlepool Now app, which will be loaded on their tablet devices. Social care staff will train the Fire Brigade on how to use the app and how to support people to navigate through the various options. If a person is identified as having needs that cannot be met by low level services or existing community resources, the Fire Brigade will be able to make a referral to the Early Intervention Service for further support, initially through reablement and potentially through a full social care assessment if required.

Establish a Befriending Network

The 2015/16 BCF Plan includes a commitment to 'help identify and combat social isolation, as a major influence on overall health and wellbeing'. There are a number of services already in place which aim to help tackle the issue of social isolation (such as luncheon clubs) but these services primarily support people who already have some identified social care needs. There is a gap in services in Hartlepool in relation to befriending for people who may be socially isolated and at risk of developing health and social care needs, or who are not currently in contact with services. Befriending services have been piloted in neighbouring authorities and have demonstrated positive outcomes within a short space of time.

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.

Typically, a client will first register an interest in a befriending scheme during a conversation with staff and details of the client's present situation and befriending needs will be gathered and assessed by the Befriending Co-ordinator. Following the initial contact, the aim is to match the older person with a suitable volunteer once one becomes available. Once a volunteer is identified, an introductory visit is then facilitated by the Befriending Co-ordinator which introduces the volunteer to the client in an informal way, usually in the client's home. If it is agreeable to both parties that the befriending continues another meeting will be scheduled the following week until the volunteer's DBS check has been cleared. The introductory process is designed

to guide the volunteer and client through the befriending aims and objectives and to allow a friendship to begin before the handover takes place. Once the DBS clearance has been received it is up to the client and volunteer to agree a regular time for the befriending to take place.

Outcomes achieved include:

- Enabling people to stay within their own homes for longer;
- Reducing social isolation;
- Reducing dependency on services;
- Increase confidence;
- Get more people volunteering, including older people;
- Create social networks;
- Reduce hospital admissions.

A Befriending Network will be commissioned by the Council during 2016/17, initially on a 12 month basis to assess effectiveness and evaluate outcomes.