Item 6 Appendix 1

Gateshead Integration and Better Care Fund Narrative Plan 2017/19

Area	**Gateshead**
Constituent Health and Wellbeing Boards	**Gateshead**
Constituent CCGs	**NHS Newcastle Gateshead CCG**

High Level Summary

Development of the Better Care Fund (BCF) Plan

NHS England published the Integration and Better Care Fund Planning requirements on 4 July 2017 for the implementation of the BCF for the period 2017 – 19. The guidance confirms the statutory and financial basis of the BCF, the main conditions of access to the Fund, Improved Better Care Fund (iBCF) and arrangements for the assurance and approval of plans.

Planning requirements

A joint spending plan that meets the national conditions will need to be developed with local partners. In developing the BCF plans for 2017-19 the following will be required, agreed, through the relevant Health and Wellbeing Boards:

i. A short, jointly agreed narrative plan including details of how we are addressing the national conditions; and how BCF plans will contribute to the local plan for integrating health and social care;

ii. A completed planning template, demonstrating:

- 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; and
- Quarterly plan figures for the national metrics.

Our approach

We tend not to differentiate between BCF and the wider approach to transformation and integration but there are specific national requirements which have been addressed.

We have tried to take a pragmatic approach and have therefore:

- Brought our narrative up to date in relation to new models of care (People Communities and Care) and some specific relevant pieces of work i.e. Intermediate Care.
- Not made fundamental changes to the pre - existing BCF “schemes”. Existing funding, held within the BCF Pooled Budget, maintains core elements of both community health and social care services, some of which are already subject to intensive redesign e.g. Intermediate Care. Although we have not rewritten the schemes the transformation activity is happening or planned.
- The CCG and LA have participated together in national webinars to develop our understanding of the “goals” and “rules” in relation to **IBCF**

- The CCG and LA have developed, and tested out with providers new schemes using IBCF temporary funds and have maintained an open and honest dialogue throughout, consistent with the culture the AOs supported us to develop eg. Statement of Intent.
- New schemes will be implemented and tested out to ensure they achieve maximum value from being positioned in a multi - agency context.
- The setting of BCF targets has been discussed in both the A&E Delivery Board and the local Governance system, and consensus reached.
- Work on the High Impact Changes (national condition 4) has been done by an operational sub group of the A&E Delivery Board and forms one of the appendices to the BCF Plan.
- The revised narrative and planning template addresses the KLOES.

Contents

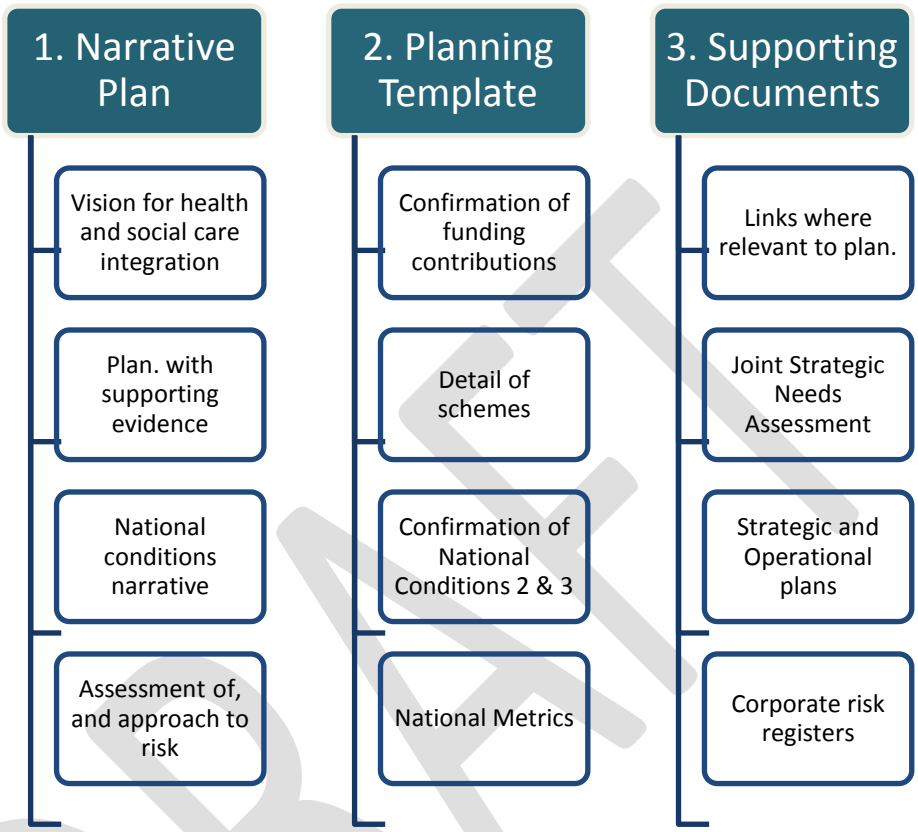
Approval and sign off

BCF plan signed off by	**Councillor Lynne Caffrey Chair Gateshead Health and Wellbeing Board.**
Date of Health and Wellbeing Board agreement	**8 September 2017**
Who has signed up to the BCF plan	**Gateshead Health NHS Foundation Trust** **Gateshead Local Authority** **NHS Newcastle Gateshead CCG** **Northumberland Tyne and Wear NHS Foundation Trust**
A&E delivery board discussion dates	**16 August 2017**

Introduction

The Gateshead Better Care Fund Plan is divided into the following sections:

Diagram 1: Better Care Fund Plan structure



This plan responds to the three sections of the Better Care Fund plan as follows:

The Narrative Plan section (pages 7 to 34) provides the main content of this document.

The Planning Template section (pages 35 to 43) refers to the confirmed funding contributions and details of schemes.

The Supporting Documents section (pages 44 to 56) includes both embedded documents and links to published documents.

Section 1 Narrative plan

Local vision, needs assessment and review

In this section we describe the local vision for health and social care services in the Gateshead system, the plans for transformation of services, implementing the vision of the Five Year Forward View and integration of health and social care services by 2020.

We set out the background to the local health and care economy and describe our plan to develop and implement our new model for care outside of hospital. There is also recognition of the challenges we face across our local health and care economies, as articulated within our local Joint Strategic Needs Assessment (JSNA).

We also review previous BCF plans, our progress against those plans, and how this has informed our current plan for 2017/19.

Our vision for health and social care was articulated within our original BCF submission (Part 1, section 2). It has subsequently informed the development of our strategic plans across our health and care economy in the Operational Plan for 2017/19, the Newcastle Gateshead chapter of an emerging Sustainability and Transformation Plan (STP) for Northumberland Tyne and Wear and North Durham (NTWND) (2016/17 to 2020/21) and more recently, the development of our local model for care outside of hospital; - People, Communities and Care.

Our BCF plan remains a core vehicle of our local economy's approach to future Health and Social Care integration (and wider) as set out in Vision 2030.

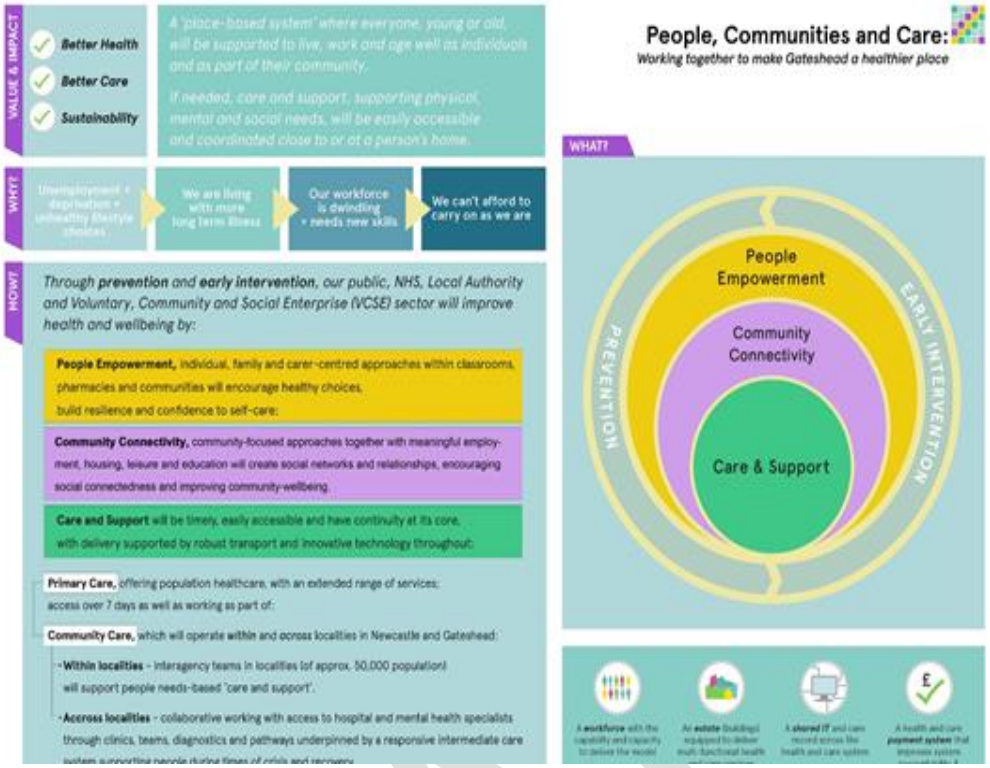
Vision 2030 is Gateshead's Sustainable Community Strategy which sets out the following ambitious and aspirational vision for Gateshead:
"Local people realising their full potential, enjoying the best quality of life in a healthy, equal, safe, prosperous and sustainable Gateshead."

http://www.gateshead.gov.uk/People%20and%20Living/communitystrategy/Vison2030.aspx

People, Communities and Care Model

At the heart of this vision is a recognition that our Health and Social Care system requires new models of care delivery across care settings with a focus on 'care outside of hospitals'. This, in turn, needs to be underpinned by a sustainable system which has 'prevention' and 'early intervention' at its core supported by 'connected communities', where people, families and communities have strong, empowering and enduring relationships. In summary, this describes our newly designed 'People, Communities and Care' (PCC) model, articulated in the following diagram:

Diagram 1 - People Communities and Care model Gateshead



See Section 3 full size copy

The **People, Communities and Care (**PCC) model for Gateshead and Newcastle has been developed over the last 12 months through a range of stakeholder conversations. Describing a system architecture designed to shift care from hospital settings to community settings and ideally to people's own homes, the model captures work already underway in many parts of the Gateshead geography.

The model will not duplicate existing work – but will bring into a coherent story, the collective efforts of statutory, voluntary, community and third sector agencies.

Transforming health and care services needs to start with the creation of a model that is well understood and agreed by all parties; having achieved that understanding and agreement, we now need to move to an implementation phase where we systematically create the out of hospital system that ensures we maximize the ability of our population (across all ages) to live independently and in their own homes – receiving hospital treatment only when it really is needed and there is not viable alternative.

The implementation must also build upon the already well established working arrangements across Gateshead – there are not only good interagency relationships at all levels of organisations, but also great examples of joint working and innovation to be capitalised upon; for example, the development of the Gateshead Care Partnership.

The Gateshead Care Partnership is an innovative partnership formed between Gateshead Health NHS Foundation Trust, Gateshead Local Authority, Northumberland Tyne and Wear NHS Foundation Trust and CBC Health, to deliver integrated community services for Gateshead residents.

How our People, Communities and Care Model operates

People Empowerment and Connected Communities **- work together to help the population live healthy and happy lives, independently and at home and that means first and foremost focussing upon making the most of our personal health and wellbeing behaviours and our community resources and only when we need NHS or social care services, do we access them - quickly and easily.**

Care and support **- services will be designed to help people live their entire lives at home, reduce the number of people going into hospital; when people do go to hospital, they will stay there for as short a period as possible. Professionals will be asked to collaborate with colleagues and help wrap their services around the person.**

Out of hospital care and support will be underpinned by a 'joined-up' system, with services across general practice, community services and social care delivering support to people that is coordinated and person-centred:

- ✓ General Practice - with growing demand and increasing complexity of illness being managed out of hospital the aspirations of the GPFV, are key to general practice being able to play an integral part in the development of our vision for out of hospital services. The CCG is already investing directly in transformation in general practice, funding transformation teams in both Gateshead and Newcastle. The aim is to support general practice to develop a vision for working at scale and new models of care and to support the development and implementation of the General Practice Forward View (GPFV) initiatives.

- ✓ Community Services and Intermediate Care - the developing models for community provision and a strong, responsive intermediate care system as well as the emerging same day accessibly urgent care model will further provide good foundations for the development of the out of hospital model.

- ✓ Social Care and Voluntary Community Social Enterprise (VCSE), in particular carers organisations, strengthening and supporting our social care and VCSE sector together with a robust, responsive and sustainable domiciliary and reablement care will be a crucial part of our PCC model.

Impact for our population – what will be different

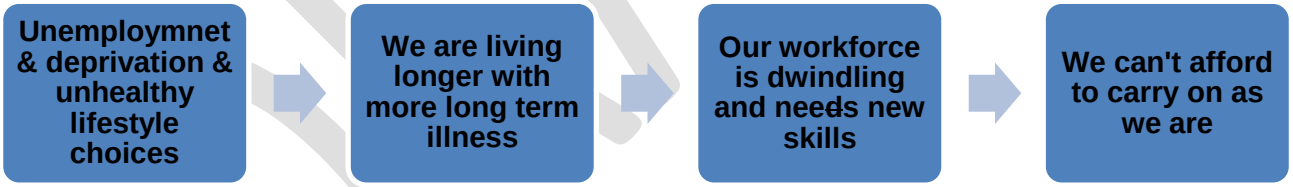
It is crucial this work is seen part of a whole 'system' model - embraced and implemented across all stakeholders and our public and patients. Therefore, the PCC model will be designed to deliver improved outcomes for the population in terms of their personal health and wellbeing behaviours as well as improve the quality of care delivered and help us meet our current funding challenges within the system. We will strive to exceed National standards around quality and safety and achieve recognised 'best practice' measures and metrics already in place within the current system.

Further work is underway to consider a system 'outcomes framework' for the PCC model, including patient experience, and (informed by National and regional work). Key metrics to assess impact of our Intermediate Care system will be go beyond the National BCF measures and reflect National work on outcomes around Intermediate care. (National Audit of Intermediate Care.) See Section 3 supporting documents for the audit framework (audit report expected Autumn 2017).

1.2 Needs assessment and review

The following highlights the key issues and challenges we face:

Diagram 2: The challenges for Gateshead



As in previous years, partners in Gateshead have committed to work together through a single policy approach, underpinned by the Joint Strategic Needs Assessment (JSNA). This takes an integrated and holistic approach to the wellbeing and health of people in Gateshead. The key ongoing challenges and emerging issues to health and wellbeing in Gateshead are presented across the life course. http://www.gateshead.gov.uk/Health-and-Social-Care/JSNA/home.aspx

The JSNA enables us to understand the key issues facing people in Gateshead and is used to identify key strategic priorities to improve the health and wellbeing of our population and includes a range of quantitative and qualitative data that we will be using to track changes to wellbeing and health at a population level, with a particular emphasis on social inequity in wellbeing and health. This approach recognises that

health (and ill-health/disease) arises from a complex interaction of different factors which are not limited to the work of health and care services alone.

The following sections of our JSNA highlights our:

- Local demography and future demographic challenges
- Current state of the health and adult social care market
- Key issues and challenges

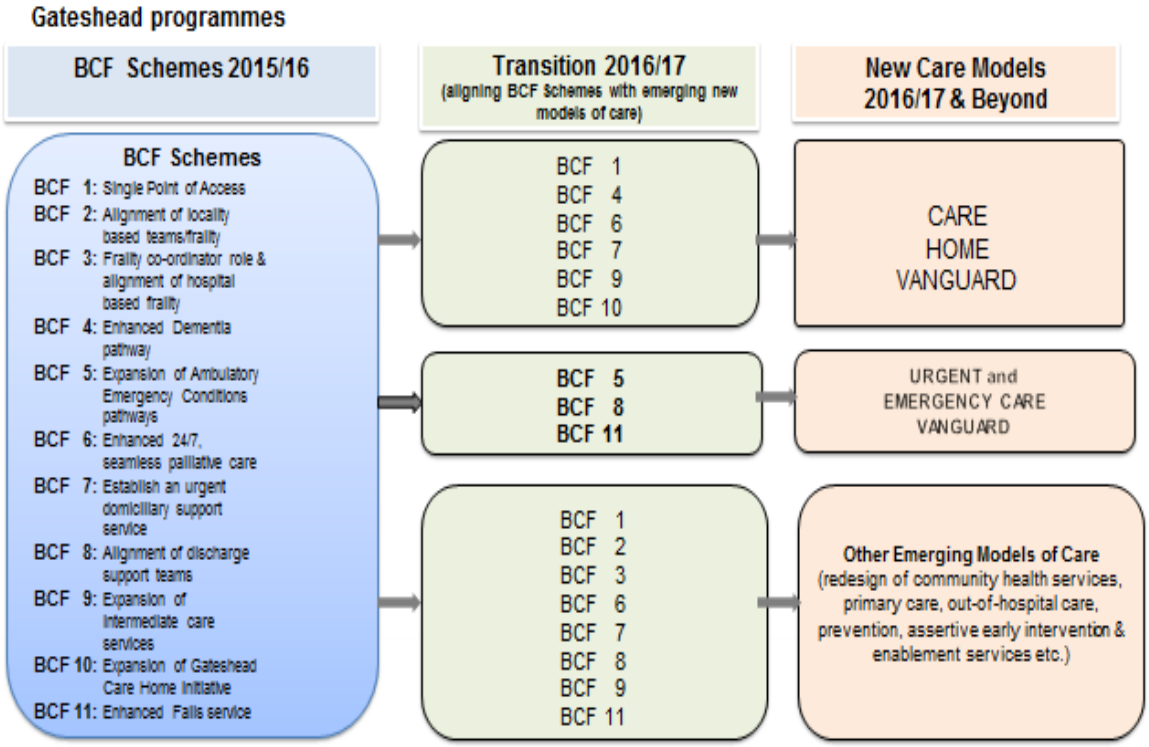
http://fingertips.phe.org.uk/profile/health-profiles/data#page/1/gid/1938132701/pat/6/par/E12000001/ati/101/are/E08000037/iid/1730/age/1/sex/4

http://www.gateshead.gov.uk/Health-and-Social-Care/JSNA/Topics/Population-and-Deprivation/Demography/Demography.aspx

Review of our previous Better Care Fund Plans

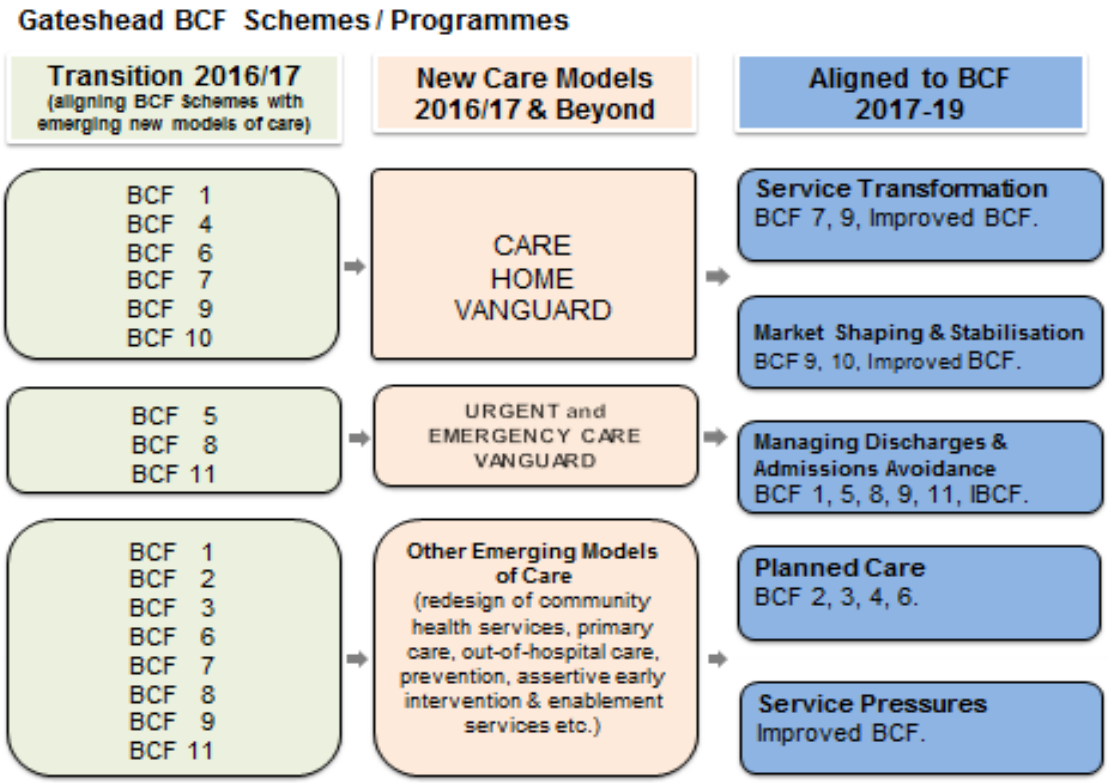
In building upon our BCF submission for the period 2014/15 to 2015/16 and working towards our longer term aspirations, 2016/17 represented a transition year where our 11 BCF schemes were aligned with our emerging new models of care (see illustration below).

Diagram 3: BCF 2016/17 transition



Our BCF Plan for 2017-19 further builds upon this approach. The illustration below demonstrates how the original BCF schemes have been re-aligned against key initiatives linked to our new models of care.

Diagram 4: BCF 2017/19 transition



Moving beyond 2016/17, our BCF (aligned merging new models of care) will transition into the PCC model being developed and implemented across the Gateshead system. Work programmes within original BCF plans naturally migrate into the 'care and support' component of our PCC model and more specifically could be considered under the '*intermediate care'* system umbrella term.

Intermediate Care in Gateshead

As a system we recognise that here are five key points within a person's journey where they could benefit from intermediate care:

- When there is a high risk of decline in independence, health and wellbeing resulting in the need for long term support;
- When they are already receiving support and there is a change in their level of independence;
- When there is potential that they may be admitted to hospital;
- To support timely discharge; and
- When there is a potential admission to a care home.

Therefore, as a major part of the PCC model, the intermediate care system in Gateshead means that services are:

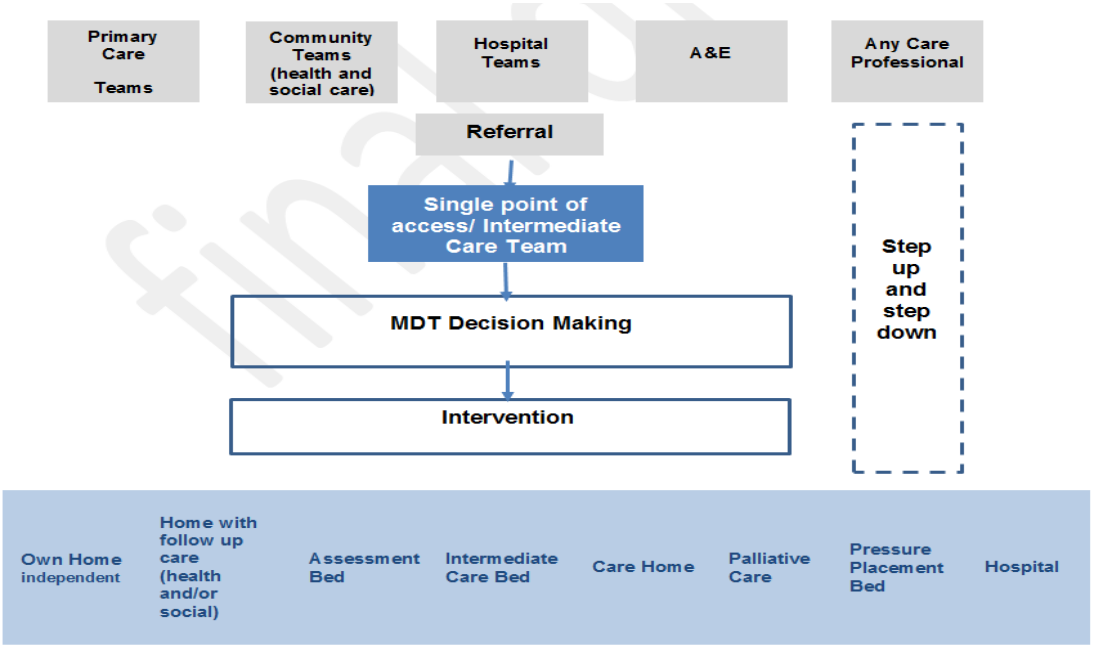
- Targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- Provided on the basis of an evidence based comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery. Comprehensive assessment and care planning to cover physical, mental and social needs
- Have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- Are time-limited, normally no longer than six weeks (though there are sometime exceptions) and frequently as little as one to two weeks or less.
- Involve practitioners and organisations working with a single assessment framework, single records and shared protocols.
- Ensure an integrated and holistic approach to physical and mental health care needs that is closely aligned with other mainstream health and social services such as elderly care, psychiatry of old age, housing, primary care etc.

The new model can then use the expertise of the multi-disciplinary team to agree the most suitable intervention for each individual – maximising independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We have adopted a 'think home' first model for assessment and have agreed a shift to an assessment culture that responds to the question "why not home?"

Getting the model right in Gateshead means that people will:

- Improve and/or maintain their independence, health and wellbeing
- Have a managed decline in independence, health and wellbeing
- Have their ability to live independently maximised
- Avoid unnecessary hospital admission
- Be in hospital no longer than is necessary
- Avoid premature admission to long term residential care

Diagram 4: Intermediate Care Model – Gateshead



What has worked well – building on our highlights and successes

Improvement in our BCF performance metrics has been demonstrated in most areas against a backdrop of demographic and financial pressures, although the performance trajectories have not been met in all areas.

Highlights - Local learning event

We hosted a local learning event in Gateshead Newcastle on 9th May, meeting with the central BCF team and wider North East BCF colleagues.

We used this opportunity to highlight the excellent integrated working happening across the Gateshead local health and care economy showing both the pro active and reactive elements and how these link with BCF and progression to the Out of Hospital Model (People, Communities & Care).

As a system we gained a huge amount from having the opportunity to talk to the central team who said it was useful to see at first hand the Intermediate care schemes and they were very impressed by the clear dedication and commitment of all the staff. We discussed with the team some of the complexity, challenges and blockages in the system.

Successes include

- Admissions into residential or nursing care

From April 2016 to March 2017, there were 324 permanent admissions into residential or nursing care. This represents 839.3 admissions per 100,000 population (based on 2014 population projections) showing a significant improvement in performance compared to the same point last year of 433 (1144.4 per 100,000 population) and has seen the year-end target of 388 admissions being achieved (1,005.1 per 100,000 population). The improvement in performance can be attributed to the introduction of a panel process in April where service managers have closer scrutiny and control over new admissions.

- Non Elective activity

Cumulative data for 2016/17 shows that Non Elective activity is below planned trajectory across the Gateshead HWB footprint, with 21,883 actual admissions against a plan of 22,979.

- Dementia

Dementia diagnosis has improved throughout 2016/17 despite a slight dip below the 70% target in Q4 to 69.9%. The rate is currently above the national standard and work continues to recover the rate seen earlier in 2016/17. In terms of continuous improvement the Care Home Vanguard team have identified from a clinical audit that 62% of people in care homes have a formal diagnosis of dementia, but considering those living with cognitive impairment without a formal diagnosis this figure could be around 72%.

Therefore work is underway to explore the development of a bespoke Dementia diagnosis pathway for Care Home residents

Achievements include:

The Care Home Project (Gateshead and Newcastle) is already delivering improvements in outcomes for the Care Homes residents. The figures below relate to Gateshead :-

- A&E attendances – 3.4% reduction comparing 2015/16 to 2016/17 for the care home population. For the wider population (over 65s) this has increased by 3.1%. Learning to date suggests that in order to identify who has the most complex needs it is becoming important to separate out the age bands into 65-79 and those over 80. Coupled with the introduction of eFI (electronic frailty index) in primary care this should facilitate the identification of those who would benefit most from case management.

- Non elective admission reduction –28.3% reduction in non-elective admissions. Learning to date highlights the most common reasons are UTI (17.4%) and Chest infections (10.9%).
- Prescribing nutritional supplement reduction – current evaluation highlights a sustained reduction -13.7%
- Prescribing of low dose antipsychotic meds continues to see a significant sustained reduction (4%)
- Outpatient appointments reduction – the anticipated reduction has not been seen; more work needs to be done in order to understand the age group dynamic, and specialities considered in data collection to date.

Progress against 2016/17 BCF performance metrics

Reablement - The indicator value for Q4 stands at 80.8% (147 out of 182) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later. The value is lower than the same period last year, which was 85.6% (184 out of 215) and is also below the challenging target of 87.5%. Please see explanation and actions being taken to address this issue under the Supporting Metrics Tab.”

DTOC - Total delayed days for 2016/17 was 6372 against a trajectory of 3330. The plan for the year has therefore not been achieved.

The plan for delayed discharge has not delivered the anticipated level of improvement, more work needs to be undertaken to understand this more fully. This will include an analysis of the patient profile of this cohort.

We have discussed DTOC in more detail in the section covering National Condition 4, including our assessment against the High Impact Change Model and our collaborative and integrated approach being taken in Gateshead by all stakeholders and providers to reduce delays.

Challenges and concerns

As austerity measures bite ever deeper, we must avoid cost shift and look at risk share to maintain the good relationships and ways of working that have developed over the last few years as the BCF plans have been developed.

Better Care Fund approach 2017/19

BCF is part of the transformational work taking place in the Newcastle Gateshead Health and Care economy to develop new models of integrated delivery and integrated commissioning based on the needs of communities.

Progress continues to be made in steering the transition of the BCF schemes towards new models of care such as the Care Homes and Urgent Care Vanguards, redesign of community health services, primary care, out-of-hospital care, and prevention/assertive early intervention. This work will contribute to reducing health inequalities in the Gateshead population.

This work is also consistent with our STP and, in particular, our aspirations for Prevention, Health & Wellbeing, Out of Hospital care, Mental Health and broader acute hospital collaboration.

As we have stated above, our BCF plan is in the process of transition to the developing PCC model. The 2017/19 plan is a therefore a transitional plan and future BCF plans will follow the PCC format in full.

The Gateshead Care Partnership (GCP), representative of the Gateshead Council, Gateshead Health NHS FT, Northumberland Tyne & Wear NHS FT and Gateshead Community Based Care, is the key delivery vehicle for the transformation of community health services in Gateshead and oversees the implementation of the community health services contract.

It also has a lead role to play in taking forward the implementation of our out-of-hospital (People, Communities and Care) model for Gateshead.

GCP has built good working relationships with statutory and other partners across the Gateshead health and care economy in helping to shape delivery arrangements in line with our joint aspirations for the health and wellbeing of local people and our vision for health and social care.

Our approach to design and implementation of our PCC model will use methodology for 'change' that is:

- Underpinned by our ***'system integration'*** principles articulated within the Accountable Officer '**Statement of intent'**;
- Aligned to our adapted ***'10 step'*** approach to designing and implementing new model of care, and

- In line with 'best practice', using and exploring evidence-based intervention. In doing so, we will use local, national and international experience to shape our PCC going forward. For example, the ***'what good looks like' suite*** **of 'best practice'** interventions from the national new care model programme

See section 3 for these documents

Key schemes/pathways descriptors

Although, we are taking a whole-model approach, as well as focusing the intermediate care system, it is important to recognise 'key pathways' within the model that will be principally responsible for achieving the prescribed BCF measures and National conditions.

A brief description of our schemes /pathways is found in Section 3, Appendix 1 Table 1 for both existing and new iBCF schemes. The schemes are also mapped to the People Communities and Care model against the BCF National guidance on scheme types and aligned to the National BCF conditions.

Agreed approach to use of Improved Better Care fund money to increase capacity and stability in the care market

It should be noted that Gateshead, through the Gateshead Care Partnership is developing a service delivery model which will focus on early intervention, prevention and enablement. Alongside this there will be an imperative for keeping people in their own home for as long as possible through maximising the use of assistive technology and development of alternative interventions. The impact of the projects outlined above on reducing DTOCs will ensure people are discharged in a more timely way and also to the most appropriate place.

With this in mind the number of home care packages is likely to increase but the extent of this is still being considered as through the new delivery model the actual home care hours may be maintained; the new delivery models are still developing.

In relation to residential care there is a commitment to reduce the numbers of people in care by at least 5%, this would equate to 40 people over 2017/18, which is challenging and requires a system wide approach as outlined above. The Council and CCG are committed to optimising the use of the funding and therefore projects will be evaluated as they progress and monitored through the wider BCF governance framework.

Section 3, Appendix 1 Table 1 identifies the broad schemes within the BCF plan that will be used for market shaping and stabilisation investment in the Adult Social

Care market, especially residential and home care to increase capacity and drive up quality.

Agreed approach to use of Disabled Facilities Grant (DFG)

There is a growing evidence base about the role that housing can make to good health and wellbeing. Suitable housing can help people remain healthier, happier and independent for longer, and support them to perform the activities of daily living that are important to them – washing and dressing, preparing meals, staying in contact with friends and family.

Housing therefore has real a contribution to make to sustaining and improving outcomes for adults in Gateshead and is recognised as an important element of our Better Care Fund (BCF) planning process.

The Council will review alternative housing options when considering the adaptation required and whether there is an already adapted property within a reasonable distance. A strategic review of housing adaptations including equipment services will be undertaken during the BCF plan period to ensure efficient use of resources including assessment capacity across health and social care.

With an aging population and more people dealing with long term conditions the majority of adaptations are carried out for those aged 65+. Often a fall or fall related injury will be a trigger point to requesting a home adaptation.

Whilst the increase in DFG specific funding has continued year on year and into 2018/19, work is required to align the infrastructure in relation to occupational therapist capacity.

DFG in Gateshead

In 2016/17 326 Disabled Facilities Grant adaptations were undertaken, the forecast for 2017/18 is 340.

The most common adaptations are level access, showers and stair lifts.

The Council also funds adaptations related to Council houses with 353 adaptations in 2016/17.

1. 3 National Conditions and narrative

The following section describes how we will deliver on the 4 priority national conditions and the 3 previous national conditions for 2017/19 by summarising our:

- *Progress to date*
- *Actions to achieve national conditions*
- *Alignment with existing plans*

National condition 1: A jointly agreed plan	
Progress to date	The Gateshead BCF plan has evolved over the last few years. Our BCF plan started with 11 schemes, which naturally migrated into our evolving new models of care as part of our BCF submission for 2016/17 and more recently resulted in the development of the People, Communities and Care out of hospital system model. On 28 April 2017, the Health & Wellbeing Board considered a model then known as 'Communities and Neighborhoods', designed to shift care outside of hospital and closer to people's homes as part of the overall work to integrate health and social care across the borough. The board provided comprehensive feedback on the model, as did the other stakeholder meetings during March and April of 2017. The feedback was considered and incorporated into a refined model – which was retitled 'People, Communities and Care'. **Table 9 in Appendix 3 of Section 3** identifies the comprehensive stakeholder conversations held.
Actions to achieve national conditions	Our BCF plan for 2017 to 2019 was submitted for consideration and approval by Gateshead's Health & Wellbeing Board on 8th September 2017, prior to submission to NHS England. The BCF Plan has been developed in tandem with Operational Plans for 2017/18 the NTWD Sustainability & Transformation Plan and the wider regional planning work underway. Progress in implementing our BCF Plan for 2017-19 will be reported regularly to the BCF Programme Board and Health & Wellbeing Board as required.
Alignment with existing plans	This narrative should be read in conjunction with a number of documents with associated links as identified in section three of this narrative plan**.**

National condition 2: NHS contribution to social care is maintained in line with inflation	
Progress to date	Maintaining a stable and social care sector is clearly crucial to the success of our BCF plan. Therefore, as a local health and care economy we will continue to invest in social care.
Actions to achieve national conditions	Protecting social care services is fundamental as we start to build a sustainable local health and social care system. This change programme will be driven through the development of our PCC model together with wider strategic planning. **Social care services will be protected as we:** • Meet needs of individuals and their carers under the Care Act (2014) • Strengthen our focus on secondary and tertiary prevention for those with long term / complex conditions • Improve our Early Help offer • Provide a more comprehensive • Reshape services through the Gateshead Care Partnership • Deliver the outcomes of the High Impact Change Model Newcastle Gateshead CCG has complied with National Condition 2 and maintained its contribution to adult social care in line with inflation. The contribution of £5.898m in 2016/17 has been increased to £6.004m (1.8%) in 2017/18 and then to £6.118m (1.9%) in 2018/19. These sums are equal to the amount confirmed in the planning template. The quoted contribution in 2016/17 was already in excess of the required minimum NHS to Social Care transfer due to the Care Act funding and schemes commissioned with the LA from the CCG minimum, however the 1.79% increase to this total will not destabilise the local care and health system. The contribution continues to be spent on social care services that have some benefit to health and support the overall aims of our Better Care Fund Plan.
Alignment with existing plans	**Section 3 Appendix 1 Table 2** identifies schemes which support our planned change (including investment) into the social care sector through 2017 to 2019.

National condition 3: Agreement to invest in NHS commissioned out of hospital services	
Progress to date	Priority has been given to developing out of hospital services to ensure that effective care can be provided to patients in their own home or as close to home as possible. Community teams will be integrated to effectively fulfil their role as the first point of access for patient care. This work in 2016/17 has focused on the development of a standardised intermediate care model to ensure patients are able to be discharged from hospital when medically fit and can be cared for outside -the acute sector. Through the STP process, there is a recognition that investment in Out of Hospital services is fundamental to sustainability of the whole system, therefore ongoing modelling and redesign will help prioritise what level of investment is required to deliver this shift. Workshops have taken place since October 2016 to agree the Out of Hospital model for the STP footprint with representatives from health and social care involved in this key piece of work.
Actions to achieve national conditions	**Appendix 1 Table 3** identifies schemes which support our planned changes (including investment) into the NHS commissioned out of hospital services through 2017 to 2019. In agreeing the targets for the non elective admissions metrics we have analysed previous performance and reviewed a realistic assessment of the impact of BCF initiatives **(as described in Section 2.3).**
Alignment with existing plans	The schemes funded in 2016/17 were reviewed in light of the national requirements around NHS commissioned out of hospital services, delayed transfers of care and also maintaining social care expenditure in line with inflation. The full minimum contribution is allocated to schemes for 2017/18, and the local spending target around commissioned out of hospital services is being achieved in Gateshead plans. There are currently no funds in the plans that are deemed at risk for 2017/18, however the risk sharing agreement included in 2016/17 that has been subject to audit will essentially be rolled forward and amended where necessary. In reviewing the requirement for a risk sharing arrangement we have included an

	analysis of previous performance and a realistic assessment of impact of BCF initiatives. Schemes in 2017/18 continue to be funded broadly in line with 2016/17 as part of the transition to new models of care.

National Condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	
This high impact change model aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters. It offers a practical approach to supporting local health and care systems to manage patient flow and discharge and can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year. **Section 3, Appendix 2,** provides a current assessment of where the Gateshead system is in implementing the High Impact Change Model (HICM). The model identifies eight system changes which will have the greatest impact on reducing delayed discharge. Ensuring people do not stay in hospital for longer than they need to is an important issue for the Gateshead health and care economy.	
Progress to date	DTOCs - Total delayed days for 2016/17 was 6372 against a trajectory of 3330. The plan for the year was therefore not achieved. There appears to be a range of issues that are contributing to the lack of improvement in performance in delayed transfers, which we have reviewed as a matter of urgency, including an analysis of the patient profile of this cohort. Work has been undertaken with key partners to understand bed utilisation and the barriers to discharging patients once medically fit. A joint local plan of action (including Newcastle local Health and Care economy) is being developed which will be influenced by the need to implement 7 days working and the 8 High Impact Changes Actions (along with the other recommendations of the UEC Review). Discussions have taken place across the Gateshead footprint to ensure a standardised approach in order to reduce the number of delayed discharges.
Actions to achieve national conditions	A collaborative and integrated approach is being taken in Gateshead by all stakeholders and providers who are committed to promoting rapid and supported discharge from hospital to the most appropriate place for both Gateshead and out of area patients - in a planned manner rather than an extended length of stay in an acute hospital bed. This will have a positive impact on further reducing DTOCs. All relevant projects outlined above have been mapped to the High Impact Change model to ensure we are allocating resources appropriately to deliver the model. Specific provision is made to implement the trusted assessor model, different models of assessment and develop a 7 day discharge to enablement

process.

There is a systemic problem in Gateshead regarding the stability and capacity of the home care market, there is specific provision with the plan to address these issues together with working in partnership with our strategic health partners through the Gateshead Care Partnership to reshape community services provision including services directly provided by the Council

Work has been undertaken between the LA and the Trusts to ensure that there is a coordinated and agreed approach to DTOC (as analysis identified that there had been some changes to recording, which had not been agreed across the system).

The CCG, LA and Trusts worked together during the winter period to develop a different approach to facilitating home care packages from hospital. This was piloted as the “bridging service”, and is in the process of being evaluated. The high level feedback was positive and we are looking to develop a longer term model, through the improved Better Care Fund.

Ensuring people do not stay in hospital for longer than they need to is an important issue for the Gateshead health and care economy. Whilst much progress has already been made to improve patient flow across the whole system through the implementation of the key actions specified in the High Impact Changes model, it is intended that each year the local health economy will further develop and enhance the services available so that they progress by at least one ‘step’ per year (e.g from Established to Mature).

Section 3 Appendix 1 Table 4 identifies schemes which support our planned change (including investment) into delivering the High Impact Change Model for Managing Transfers of Care through 2017 to 2019, although other BCF and iBCF projects will have indirect contributions to these changes. Additionally it should be noted that there is a range of work on this area currently sitting outside of the BCF, and which have been referred to already in the document eg. GPFV and regional work eg Urgent and Emergency Care Network. This work is closely inter-related with our BCF plan because providing care closer to home will reduce the demand on other services.

Alignment with existing plans	Work continues to be undertaken with key partners, and discussions continue across the Gateshead footprint to ensure all work is aligned with plans and a standardised approach is in place in order to reduce the number of delayed discharges. A copy of the Gateshead Delayed Transfer of Care (DToC) Action Plan 2016/17 can be found in **Section 3.** The plan provides a detailed analysis of the actions implemented during 2016/17 to further ensure optimum health care provision. Business processes have already been robustly reviewed and embedded within every day working practice to ensure consistent, accurate and timely recording, validation and reporting mechanisms - in line with statutory definitions for a 'delay' and with national best practice for completing the statutory return.

Annex B: Maintaining progress on the 2016-17 national conditions

Although no longer national conditions we have described in the following section our plans to take forward these policy priorities and critical enablers for integration, including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

B1 Agreement on the delivery of 7 Day Services

Improving services through the implementation of the 7- day service clinical standards remains an important priority and we are working to make progress on implementing the 4 priority clinical standards, supported by NHS England and NHS Improvement.

Good progress has been made in developing 7 day working - a key focus for the CCG and its partner organisations both to effectively utilise resources as well as to provide patient centred, convenient services routinely at weekends, involving the entire team in service delivery. Plans have been developed and are being implemented, which will be further enhanced based on the recommendations of the UEC Review/ 8 High Impact Actions and local needs assessments to ensure that co-ordinated multi-agency, multi-disciplinary care is available 7 days a week.

Progress made in 2016/17

- Extended opportunities for 7 day discharge ('perfect week', MADE) in line with the High Impact Actions - key services are now available.
- Learning from Prime Minister's Challenge Fund in Gateshead to roll out extended access in Primary Care - primary care access is available in both Newcastle and Gateshead for patients who need to see a GP but who are unable to access their registered practice including during out-of-hour periods and weekends.
- Enhanced community provision which integrates with urgent and planned care services
- Think Pharmacy First Scheme continuing to be enhanced including streaming from ED to local community pharmacies in order to reduce demand for minor ailments across the system.

The Local A&E delivery board will continue to oversee achievement of the A&E target and delivery of the 5 elements of the A&E Improvement Plan; ensuring implementation of the key actions specified in the Rapid Improvement Guidance for Streaming, Flow and Discharge, working collaboratively with NEAS to assist them in delivering the Ambulance Response Programme as well as working as a key member of the Regional UEC Vanguard to deliver the Integrated Urgent Care Standards across the STP footprint**.**

Section 3 Appendix 1 Table 5 identifies schemes which support our planned change (including investment) into the delivery of 7 Day Services including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

B2 Better data sharing between health and social care, based on the NHS number:

Following initial stakeholder events held in 2015, significant progress has been made to develop more robust plans for delivering information sharing between stakeholders, including across health and social care. The CCG has co-ordinated the development of the Newcastle Gateshead Local Digital Roadmap, which outlines the ambition across Newcastle Gateshead to deliver a paper free care system by 2021. Stakeholder organisations were involved in developing this joint plan which was completed in June 2016.

The Newcastle Gateshead Local Digital Roadmap sets out ambition across several universal capabilities for shared information across care settings. The deployment of the Medical Interoperability Gateway (MIG) and Messaging Exchange for Social Care and Health (MESH) are key systems needed to achieve successful sharing of information between Gateshead Social Care and NHS partners.

The local Gateshead Information Network (GIN) continues to meet regularly and covers a range of health, social care and third sector providers. Recently it has been agreed to hold joint meetings with Newcastle, to form the Newcastle Gateshead Information Network, who will oversee the implementation of the Local Digital Roadmap. Progress has been made in the provision of patient communications at a regional level, with posters, leaflets and a patient helpline for queries around information sharing going live in September 2016.

Implementation of projects to deliver this agenda continues with sharing of patient records from primary care to our local Mental Health provider making progress, and engagement work currently being carried out with practices. This will involve sign up to an Information Sharing Gateway – a single portal to allow organisations to easily manage their information sharing agreements.

This will provide a direct link between mental health care and GP records established at the point of direct care with the patient, using a solution called the Medical Interoperability Gateway (MIG). Information sharing is also being established for all local acute trust providers, who each have plans in place to begin accessing primary care records at the point of care (with urgent and emergency care settings being a high priority).

In addition, Gateshead and Newcastle Councils are working with Health Care Gateway (MIG supplier) and the Social Care system suppliers on an integration piece with the aim of presenting Social Care practitioners with GP record information via an agreed dataset and conversely, GPs with Social Care record information. Building on the work being undertaken across organisations to facilitate the use of the MIG into social care services, officers are considering options in terms of smaller scale pilots, which will be able to test the system; identify benefits and address any operational issues. There is a view that linking this with the existing Care Homes Vanguard work may be beneficial.

The GIN meetings bring together technical experts alongside frontline staff to discuss the mapping of systems currently in use across health and social care. Through this network there is regular discussion on how to move towards system integrations, including a working towards the Open API standards.

All NHS organisations use the NHS Number as the main identifier, all organisations have processes in place to identify and fill gaps in usage of the NHS number. Usage of NHS number as the single identifier in Social Care is increasing with 90% of active social care clients in Gateshead having a matched NHS number. Work is ongoing within social care to increase this by mapping business processes and working with frontline staff to promote its use.

In the last six months Newcastle Hospitals NHS Foundation Trust and Northumberland Tyne and Wear Mental Health trust have both been identified as Global Digital Exemplar sites. This may present opportunities to further this area of work and this is being explored.

Section 3 Appendix 1 Table 6 identifies schemes which support our planned change (including investment) into the delivery of Better data sharing between health and social care, based on the NHS number including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

These changes will enable us to connect existing services to reduce duplication and improve the experience of service users/patients. Care will be delivered more safely because professionals will have access to up to date information about the people they are caring for.

In 2017/18 we will continue to:

- Work with health and care teams to understand requirements for and barriers to data sharing and to test out how we address any system and mode of operation issues.
- Implement our digital roadmap for information sharing.
- Use technology to support reduction of unnecessary NELs, 7 day working,

out of hospital services, and timely discharge.

- Engage our local population on data use, access and legal rights.

B3 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

All funding for integrated packages of care are jointly agreed between CCG and LA leads. There are well established panel arrangements in place to ensure that there is a joint approach to assessments and care planning, and appropriate funding allocated. The process for jointly reviewing eligibility is also jointly agreed. Case management of CHC eligible individuals is (previously commissioned from the LA), is transferring back to the CCG; plans are being developed to ensure that the transfer of this work is managed in a safe and seamless way.

Community matrons are also key to the development of integrated packages of care; this is of particular significance in the management of long term conditions and where there is a dominance of complex specialist health care needs.

Single Point of Access and IT development work further support joint care planning arrangements, as will the redesign of community services.

As identified within our original BCF submission (Part 1, Annex 1, Scheme 4), there are a range of services within health and social care and across NHS and voluntary providers that support patients with dementia. We are continuing to work with providers to align patient referral pathways around consistent service delivery.

Local work has also been undertaken to support General Practices to identify and manage patients with dementia (e.g. care planning training). Dementia is a specific workstream of the Gateshead Newcastle Care Homes Vanguard and a service review is underway within old age psychiatry in Gateshead Health NHS FT aiming to enhance pathways in conjunction with primary care.

Section 3 Appendix 1 Table 7 identifies schemes which support our planned change (including investment) into the delivery of assessments and care planning including how they are aligned with key schemes/pathways mapped to the People Communities and Care model.

B4 Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans:

Newcastle Gateshead has well established governance arrangements supporting ‘Better Care’. There is joint ownership across both Health and LA commissioners and providers to lead on the development and implementation of the plans.

Ongoing discussions around service redesign with a shift in ‘closer to home’ provision are transparent and the implications for acute and non-acute providers both in Health and Care are understood. A shift in the ‘national conditions’ to explicit funding to support community health (including social care) underpins the ethos to Better Care, coupled with ring-fenced investment.

The current governance arrangements in ‘Better Care’ and wider system contractual and planning discussions (STP development) have enabled us to collectively understand the consequential impact on providers on our strategic plans and sign off is undertaken in the Accountable Officers Forum; this being a meeting of all of the NHS and LA Chief Executives in the health and social care economy.

1.4 Risk assessment and management

The following section the agreed approach to risk is set out, and the risks of our plan are identified, along with mitigating actions to be undertaken by the partners.

The BCF (and from 17/18 the iBCF) are covered by a S75 Agreement signed by the local authority and CCG but shared with provider partners for their involvement in governance and risk management arrangements.

The current Section 75 agreement outlines the following in terms of risk share:

- Pooled Fund Management
- Overspends
- Underspends

A copy of the agreement can be found in Section 3.

These arrangements are increasingly important given the context of further financial pressure across all partner organisations. Partners have been active in sharing and understanding financial risks and pressures across all organisations and are clear that long term benefits will only be achieved by working together.

Each partner has an efficiency programme in place to support achievement of in year and medium term financial balance with appropriate internal governance arrangements to provide assurance on delivery. In addition there is recognition of increased pressures on resilience across the whole health and social care system, noting the key roles of general practice and the voluntary sector.

Key risks and associated mitigating measures reflect the direction of travel being taken by our local system and the role of our BCF plan for 2017/19 in facilitating the transition to new care models and broader transformational change. These risks are consistent within partner organisations.

The risks have been assessed in terms of main delivery risk and current market position and rated as red, amber or green.

Assessment of risk

Risks	*Mitigation*	*RAG rating*
Relationship challenges – commissioner and providers	Our local system has good working relationships in place across the local health and care sector. Our Health and Wellbeing board and Accountable Officers Group have further developed working relationships allowing for appropriate and timely escalation of issues that need resolving but also allow for alliances and relationships to be strengthened.	
Cultural changes required and change to working behaviours/skills not adequately addressed.	There is a continuing need for work to be undertaken with all stakeholders and employees across the sector to address this requirement which is key to successful transformational change.	
IT infrastructure/sharing arrangements are not fit for purpose to support plan delivery.	Robust IT programmes are in place with multi-stakeholder arrangements. Gateshead Information Network (GIN) has a clear strategy with outcomes and are working towards an aligned system that allows a whole–system approach to care delivery.	
There is a disconnect between commissioner and provider plans	Our plans for 2017-19 have been developed in the context of a whole system view consistent with our Health and Wellbeing Strategy. Consideration has and continues to be given to the impact on providers with a view to jointly defining our direction of travel on health and care integration and transformation. Providers are core and key to all service changes and are actively co-producing the system transformation and how delivery will be implemented. The Joint Integrated Care Programme Board will have a focus on	

Risks	Mitigation	RAG rating
	planning for long term sustainability that links with the AOs group and our Health & Wellbeing Board.	
Financial risks including risk of cliff edges at the end of the funding period.	Locally, our transformational approach seeks to reduce this risk to the authority and the local system. Nationally, we are aware of the need for a longer term settlement from Government.	
The plan and supporting initiatives do not enable resources to be redirected towards redesign of care pathways towards closer-to-home care	Our plans are designed for the best interest of patients and the public to make a sustainable local health and care economy. Pathways have an evidence base, are best practice concepts and are what works locally. Changes are being considered in relation to whole-system transformation and new funding /payment systems (e.g. new models of care) that will allow risk sharing arrangements with providers, new service configurations (e.g. alliance networks) and focus on rewarding value-based outcomes across health the social care economy.	
Pressures on the acute sector are not reduced and demand continues to grow across the system with significant and continued financial consequences	Our transformational plans have a strong focus on prevention, wellness and are adopting alternative pathways of care with investment into the out-of-hospital sector. Aligning health and social care efforts with a big push towards wellness, we will hopefully start to see a reduction in 'needs' and an expansion in wellness. Focusing on the high demand cohorts for the acute sector (e.g. older people) will hopefully start to reduce activity as alternative pathways of care start to come on line. Through our most senior forum e.g. Accountable Officers Group we will manage system and service resilience whether through pressures such as surge, financial or through transformation.	

Risks	***Mitigation***	***RAG rating***
Financial pressures in CCG budgets as a result of demographic growth and living wage.	CCG QIPP programmes in place with a PMO established to drive implementation and provide assurance on delivery.	
In Primary Care there is a significant increased workload so that Practices are already under critical pressure to maintain current access and care. Workforce gaps particularly GP and Practice nurse; likely to get worse due to demographic workforce skewed to near end of career; and failure to recruit new GP and Nurses in sufficient numbers. No growth in funding to Practices for last 10 years (though some limited and/ or short term funding GPFV)	The CCG is actively engaged in workforce strategy development as members of the Health Education England (HEE) local workforce action board and group. Based on emerging evidence and best practice from the groups above, the CCG is developing workforce solutions to fit the developing out of hospital model, looking at potential skill mix options and integrated roles. This includes access to International Recruitment to increase workforce capacity. Use of HEE NE workforce tool to understand /assess the workforce profile of our practices will allow us to develop future CPD needs and allow us to map the workforce in Newcastle Gateshead	

RAG ratings

Red – significant risks remain which could impact on delivery of the BCF plan and objectives

Amber – progress being made but a degree of risk remains which could impact on delivery of the BCF plan and objectives

Green – no concerns highlighted which could impact on delivery of the BCF plan and objectives

Section 2 Planning Template
2.1 Confirmation of funding contributions

The following section summarises the planning template which will be submitted alongside our narrative as part of the overall BCF plan.

The funding contributions for the BCF have been agreed and confirmed, including agreement on identification of funds for Care Act duties, Reablement and carers breaks from the CCG minimum. The excel Planning Template confirms the financial details for the following areas

- Care Act
- Carers' breaks
- Reablement
- DFG
- iBCF

The use of this funding is described in the table below:

The amounts in the planning template comply with BCF minimum funding requirements, including;

- Mandated local contributions for Implementation of the Care Act, Reablement and Carers Support
- Minimum contribution to Adult Social Care has been maintained in line with inflation, based on 1.79% uplift in 2017/18 and 1.9% uplift in 2018/19
- Funding for NHS Commissioned Out of Hospital Services had been maintained above the ringfenced minimum, as in 16/17.
- Disabled Facilities Grant as per minimum contributions set out in the template

- Plans for the use of the full IBCF grant meet all of the purposes set out in the grant determination and there has been no offset against the contribution from the CCG minimum.

Stakeholders have been involved in the production of the BCF and iBCF schemes for 2017/18 and support the approach taken. The iBCF final schemes were agreed by the CCG and the Local Authority in August 2017.

iBCF Funding

Plans for the use of iBCF money meet all of the purposes set out in the grant determination ie:

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

There has been no offset against the contribution from the CCG minimum.

Details of the BCF schemes and iBCF schemes can be found in **Section 3 Appendix 4 .**

2. 2 Programme Governance

The following section sets out the governance arrangements for integration work in Gateshead, within which context the BCF will sit.

Strategic ownership and leadership

In January 2017, the six accountable officers across Newcastle and Gateshead (three main foundation trusts, two councils and one CCG) signed a 'statement of intent' that describes their shared commitment to working together across organisational boundaries to improve population health and social care outcomes and create:

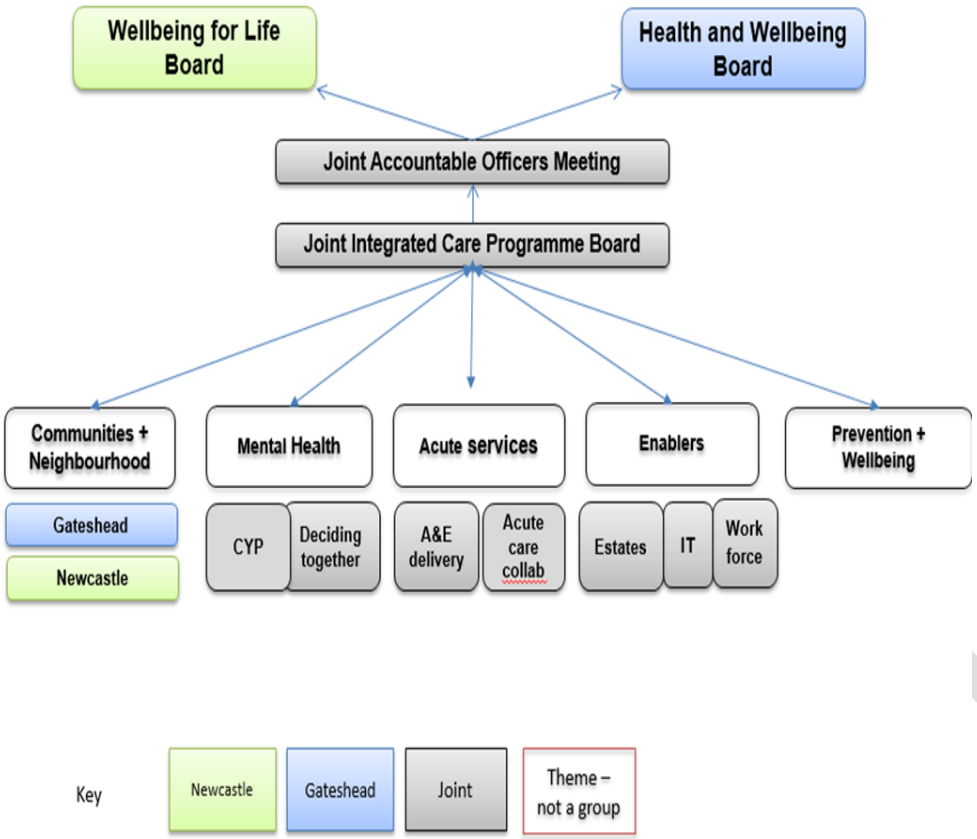
- A continuing and sustained improvement in the health and wellbeing, evidenced by greater longevity and better outcomes from health and social care interventions.
- Greater equality of outcomes delivered through the highest quality health and social care.
- An appropriately integrated and well planned, effective delivery model for health and social care, which is efficient in its use of resources.
- A delivery system that is responsive to the needs of users in the short term and additionally, in the longer term, supports communities to be more responsible for the achievement of these objectives.

The statement of intent is based on the Canterbury model of Distributed Leadership; a copy can be found in **Section 3**.

Using the working title of 'Accountable Care Partnership' the accountable officers are leading the integration work in Gateshead and in Newcastle under the auspices of the Gateshead Health and Wellbeing Board and Newcastle Wellbeing for Life Board. To ensure the work moves forward with pace, a jointly funded post of Director of Transformation and Integration has been appointed who reports to all 6 Chief Executives and has lead director responsibility for the main integration programmes currently underway.

We are already seeing the benefits of having this innovative post in place in terms of supporting the system The diagram below describes Newcastle Gateshead system governance and how the PCC work programme (incorporating BCF) will be designed, implemented and monitored.

Diagram 5: Integration Governance Arrangements



The Joint Integrated Care Programme Board will enact the shared strategic vision for health and social care across the Gateshead and Newcastle health and care economy, as described in the statement of intent (January 2017) as follows:

> *The vision of the partners is that Newcastle and Gateshead is a model for how every part of the health social care and third sectors can work together to enable the people they serve to live longer, healthier lives, supported by the very best services available.*

The Board will oversee the planning, transformation and delivery of high quality, integrated health and care services. It includes representation from:

- Newcastle Gateshead Clinical Commissioning Group
- Gateshead Metropolitan Borough Council
- Newcastle City Council
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- North East Ambulance Service NHS foundation Trust
- Community Based Care Gateshead
- Newcastle GP Federation

- Bluestone consortium
- Newcastle Council for Voluntary Service (on behalf of Newcastle and Gateshead VCS)
- Healthwatch Newcastle
- Healthwatch Gateshead

The Joint integrated Care Programme Board will report progress to the Joint Accountable Officers Meeting. It will also make recommendations to the Joint Accountable Officers Meeting and, in turn, the relevant decision making arrangements within each partner agency.

A Section 75 agreement has been concluded in previous years in line with required levels and is in draft for 2017/18 between Gateshead Local Authority and the CCG.

BCF Reporting - Add the wider BCF governance framework.

Progress in implementing our BCF Plan for 2017-19 will be reported regularly to the BCF Programme Board and Health & Wellbeing Board as required. The BCF Programme Board will monitor progress against our schemes and plans to meet the national conditions, as well as performance against key metrics linked to the BCF. It will also monitor the Expenditure Plan in line with the arrangements set out in our Section 75 agreement.

The Health & Wellbeing Board will receive regular updates on our BCF Plan, performance against key BCF metrics and planning returns to be submitted to NHS England.

2.3 National Metrics

The following section summarises our targets across the 4 national BCF metrics, and our plans for achieving them.

In agreeing the targets for the following metrics we have identified the process followed, including analysis of previous performance and a realistic assessment of the impact of BCF initiatives:

A Non elective admissions
B Admissions to residential and care homes
C Effectiveness of reablement
D Delayed transfers of care

Summary of BCF metrics

Better Care Metrics	2016/17 Baseline	2017/18 Target	2018/19 Target
Total non-elective admissions to hospital (general & acute) all age per 100,000 population	21,883	22,208	22,579
Permanent admissions for older people (aged 65 and over) to residential and nursing homes, per 100,000 population	855.6	950.5	854.4
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	80.8%	85.7%	87.9%

Delayed transfers of care (delayed days) from hospital per 100,000 population (18+)	Q1	Q2	Q3	Q4
2016/17 Baseline (Quarterly Rate)	884.8	1007.6	1142.1	919.6
2017/18 Target (Quarterly Rate)	851.0	646.9	625.8	625.7
218/19 Target (Quarterly Rate)	625.7	625.7	625.7	625.6

A Non-elective admissions:

Cumulative data for 16/17 show that Non Elective activity is below planned trajectory across the Gateshead HWB footprint, with 21,883 actual admissions against a plan of 22,979. The CCG total NEA plan for 2017/19 is taken from the latest CCG NEA

plan figures aggregated to quarterly level, and calculated Non Elective activity plans are based on the Commissioner Operational Plan submissions for 17/18

- The CCG NEL plan is based on:
    - 2016/17 Forecast Outturn (at the time)
    - Plus 2.4% Growth as per STP assumptions
    - Adjustment for changes to Spec Services IR rules
    - Reduction for QIPP schemes and Vanguard impact

As part of our planning round this has been checked against signed contract and therefore should tally with the activity expectations across all Secondary care providers.

B Admissions to residential homes and care homes:

For April 2016 to March 2017, there were 328 permanent admissions into residential or nursing care. This represents 855.6 admissions per 100,000 population (based on 2014 population projections) showing a significant improvement in performance compared to the same point last year of 433 (1144.4 per 100,000 population) and has seen the year-end target of 388 admissions being achieved (1,005.1 per 100,000 population). The improvement in performance can be attributed to the introduction of a panel process in April where service managers have closer scrutiny and control over new admissions.

Given that the 2016/17 performance represents a significant improvement on 2015/16, the challenge will be to maintain this. The permanent admissions plan has been set for 17/18 as 950.5. This is an increase in admissions from 2016/17 but takes into account the fact that we have already seen an increase in admissions for the first 4 months of this period. The plan would be to achieve 16/17 rate in 18/19 (854.4 – 336 admissions). This is still significantly better than the 16/17 plan.

The panel continues as a gatekeeper to all residential placements to ensure continuity and rigour for the application of alternatives to residential placements and to also review the referral pathway to determine whether BCF initiatives had been or could have been deployed.

C Effectiveness of reablement:

Performance for Q4 2016/17 was 80.8% (147 out of 182) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later. The value is lower than the same period 2015/16, which was 85.6% (184 out of 215) and below the challenging target of 87.5%.

Given the reduction in performance levels in 16/17 to 80.8%, the plan for 2017/18 is to reach the 2015/16 performance level at 85.7% and then in 2018/19, sufficiently improve to reach 16/17 plan of 87.5%.

Working in a cycle of continuous improvement, and taking the learning from clinical audits, formal evaluations and anecdotal evidence a number of changes have occurred in the past year. This has resulted in some services integrating to standardise practice and mitigate against the risk of fragmentation. Adult social care has therefore developed a new enablement model which significantly increases the reablement capacity at a Single Point of Access and provides multi-disciplinary interventions to clients entering into the system. The new and extended model recognises the need for both home based and bed based services to develop and maintain independence.

The model has been established through the repositioning of long term domiciliary care services from being delivered by in-house services to being delivered by the independent sector and diverting released resource to focus upon prevention, intervention and rehabilitation.

D METRIC Delayed transfers of care (DTOC) plan

This section needs to be reviewed alongside the section on **National Condition 4 Delayed transfers of care.**

On July 3rd 2017, Jeremy Hunt released a ministerial statement outlining the importance mimimising delayed transfers of care so that no-one stays in a hospital bed longer than necessary: it removes people's dignity, reduces their quality of life; leads to poorer health and care outcomes for people; and is more expensive for the taxpayer.

The 2017/18 mandate to NHS England outlined the clear expectation that delayed transfers of care (DToCs) should equate to no more than 3.5% of all hospital beds by September 2017. Since February 2017, there have been significant improvements within the health and care system nationally, with a record decrease in month-on month delayed discharges in April 2017.

On this basis discussions have taken place with system partners in order to agree the trajectories outlined below and in line with the national expectations described within the mandate.

In line with the trajectories previously set, the following rationale has been used in setting the trajectories for the 2017/19 plan. The agreed trajectories are:

Gateshead **Social care attributed delays** need to reduce from approx 7 people on average delayed per day to 4 people on average delayed per day by September and maintained through the year. This equates to approx 120-130 per month (depending on rounding and days in the month this varies). This will ensure Gateshead social care attributed delays are meeting the national requirement of 2.6 delayed days per day per 100,000 population by September. Given the challenges to achieve this reduction, the plan is to maintain this level throughout 2017/18 and 2018/19.

For Gateshead HWB **NHS attributed delays** for Gateshead, the rate of approx 202 delayed days per month needs to be maintained.

Actions to ensure delivery of the DToC metric are covered in detail in the section National Condition 4 Implementation of the High Impact Change Model.

DTOC technical detail

DTOCs – Total delayed days for 2016/17 was 6372 against a trajectory of 3330 and therefore the plan for the year has not been achieved.

The plan for delayed discharge has not delivered the anticipated level of improvement, more work is being undertaken to understand this more fully. This will include an analysis of the patient profile of this cohort.

As per the NHS England 2017/18 Mandate, total DToC (NHS, adult social care and jointly attributable combined) should be reduced by September 2017, and the overall reduction in DToC should be equal (50%:50%) between the NHS and social care.

Given that Gateshead Health NHS FT DTOC performance falls below the minimum threshold for NHS attributed delays of 3.5% (2.2% Q4 16/17 baseline), trajectories have been set so that this level is maintained to September 2017 and beyond.

In terms of social care attributed delays, the best performing LAs have 2.6 people delayed in hospital per 100,000 adults due to social care. Social care delays above the 2.6 per 100,000 requirement are to be reduced, in line with the 2017/18 mandate As at the February 2017 baseline, the rate of social care attributed delayed days is 4.1 per 100,000 in Gateshead. This is to be reduced to a rate of 2.6 per 100,000 population and trajectories have been set to maintain this level, in line with the NHS 17/18 Mandate.

Section 3 Supporting documents

Name	Location
Page x Diagram - People Communities and Care model Gateshead	 People%20Communi ties%20and%20Care
National Audit of Intermediate Care Framework document 2017 Report expected September 2017.	 Copy of NAIC 2017 - Provider data specifica
Accountable Officers Statement of Intent Principles and system integration principles	 Statement%20of%2 0Intent%20Final%20
Adapted Principles - 10 step approach to creating a new model	 Revised%2010%20s teps%20to%20a%2(
What good looks like suite of best practice	 What_does_good_lo ok_like_document_FIl
Section 75 agreement	 NHS%20Newcastle %20Gateshead%20C
Table 1 description of key schemes/pathways mapped to the People Communities and Care model, against the 'scheme type' headings within the BCF National guidance and aligned to the National BCF conditions. National conditions Table 2,3,4 Annexe B schemes aligned Tables 5,6,7,8	Appendix 1
Table 9 stakeholder conversations held during the development of the People Communities and Care Model	Appendix 2
Current assessment of implementing High Impact Change Model (HICM	Appendix 3
BCF plan 2014 BCF Plan update 2016	BCF Plan 2014 can be accessed at: http://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2015/03/BCF-Gateshead-Part-One-Version_12-Final.pdf

	BCF Update 2016 Final Gateshead BCF Narrative submission 3
NHS Newcastle Gateshead CCG Operational Plan 2017/19 including GP Forward View	The plan can be accessed at: http://www.newcastlegatesheadccg.nhs.uk/wp-content/uploads/2017/04/17-19-NHS-Newcastle-Gateshead-Operational-Plan-FINAL.pdf
Northumberland Tyne and Wear and North Durham Sustainability and Transformation Plan (NTWND STP) (2016/17 to 2020/21)	The STP can be accessed at: http://www.newcastlegatesheadccg.nhs.uk/get-involved/stp/
Accountable Officer Statement of Intent & system integration principles	Statement%20of%20Intent%20Final%20
BCF progress reports to Health & Wellbeing Board	All HWB papers can be access at: http://democracy.gateshead.gov.uk/ieDocSearch.aspx?Err=1&CI=153&SD=01%2f01%2f2017&ED=31%2f07%2f2017&DT=1&WI=0&IID=0&IT=0&IS=&CA=false&SB=true&ST=&ADV=1 BCF Updates were discussed in: March 2017 April 2017 June 2017 July 2017
DTOC – copy of the Gateshead Delayed Transfer of Care (DTOC) action plan 2016/17. The plan provides a detailed analysis of the actions implemented during 2016/17 to further ensure optimum health care provision.	Appendix 2 Gateshead DTOC Actic Appendix 3 DTOC Plan trajectory.docx
Local Digital Roadmap	http://www.newcastlegatesheadccg.nhs.uk/newcastle-gateshead-local-digital-roadmap/

Appendices

Appendix 1

Table 1 sets out *our **key schemes/pathways descriptors**, mapped to the People Communities and Care model, against the 'scheme type' headings within the BCF National guidance and aligned to the National BCF conditions.*

PCC model Component	Scheme Type	Existing BCF	New iBCF	1617 National Condition	1718 National Condition
PE	1. Assistive Technologies				
CC	2. Care navigation / coordination				
CS	3. Carers services	Carers			Invest in Out of Hospital Services Cont to ASC Maintained
CS	4. DFG - Adaptations	DFG			
CC	5. DFG - Other Housing	DFG			
CS	6. Domiciliary care at home	Planned Care	Market Shaping and Stabilisation	7 Day Services	Invest in Out of Hospital Services Cont to ASC Maintained
		Transformation	Service Pressures		
Whole Model	7. Enablers for integration	Transformation	Service Pressures	Data Sharing	Cont to ASC Maintained
			Transformation		
CS	8. Healthcare services to Care Homes				
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance	Managing discharges and Admission Avoidance	Care Planning 7 Day Services	Invest in Out of Hospital Services Cont to ASC Maintained Transfers of Care
		Planned Care			
CS	10. Integrated care planning	Market Shaping and Stabilisation	Managing discharges and Admission Avoidance	Care Planning	Cont to ASC Maintained Invest in Out of Hospital Services
		Planned Care	Service Pressures		
CS	11. Intermediate care services	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services	Cont to ASC Maintained Invest in Out of Hospital Services
		Market Shaping and Stabilisation			
		Transformation			
PE	12. Personalised healthcare at home		Social Care and health personal budget infrastructure		
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services	Cont to ASC Maintained Invest in Out of Hospital Services
CS	14. Residential placements	Market Shaping and Stabilisation	Market Shaping and Stabilisation	Care Planning	Invest in Out of Hospital Services
			Service Pressures		
PE	15. Wellbeing centres				
	16. Other	Managing discharges and Admission Avoidance			

KEY: PE – people empowerment, CC- connected communities, CS – care and support

Appendix 1 Table 2 *identifies schemes which support our planned change (including investment) into the social care sector through 2017 to 2019.*

National Condition 2: NHS contribution to social care is maintained in line with inflation

PCC model Component	Scheme Type	Existing BCF
CS	3. Carers services	Carers
CS	6. Domiciliary care at home	Planned Care
Whole Model	7. Enablers for integration	Transformation
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance
CS	10. Integrated care planning	Market Shaping and Stabilisation
CS	11. Intermediate care services	Managing discharges and Admission Avoidance
		Transformation
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance

Appendix 1 Table 3 *identifies schemes which support our planned change (including investment) into NHS-commissioned out-of-hospital services through 2017 to 2019.*

National Condition 3: Agreement to invest in NHS-commissioned out-of-hospital services

PCC model Component	Scheme Type	Existing BCF
CS	3. Carers services	Carers
CS	6. Domiciliary care at home	Transformation
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance
		Planned Care
CS	10. Integrated care planning	Planned Care
CS	11. Intermediate care services	Market Shaping and Stabilisation
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance
CS	14. Residential placements	Market Shaping and Stabilisation

Appendix 1 Table 4 *identifies schemes which support our planned change (including investment) into delivering the High Impact Change Model for Managing Transfers of Care through 2017 to 2019*

National Condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

Managing Transfers of Care			
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance Planned Care	Managing discharges and Admission Avoidance

Appendix 1 Table 5 *identifies schemes which support our planned change (including investment) into the delivery of 7 Day Services including how they are aligned with* key schemes/pathways mapped to the People Communities and Care model.

Agreement on the delivery of 7 Day Services				
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**	**1617 National Conditions**
CS	6. Domiciliary care at home	Planned Care Transformation	Market Shaping and Stabilisation Service Pressures	7 Day Services Invest in Out of Hospital Services Social Care Contn
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance Planned Care	Managing discharges and Admission Avoidance	Care Planning 7 Day Services Invest in Out of Hospital Services Cont to ASC Maintained Transfers of Care
CS	11. Intermediate care services	Managing discharges and Admission Avoidance Market Shaping and Stabilisation Transformation	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn

Appendix 1 Table 6 *identifies schemes which support our planned change (including investment) into the delivery of Better data sharing between health and social care, based on the NHS number including how they are aligned with* key schemes/pathways *mapped to the People Communities and Care model*.

Better data sharing between health and social care				
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**	**1617 National Conditions**
Whole Model	7. Enablers for integration	Transformation	Service Pressures	Data Sharing
			Transformation	Social Care Contn

Appendix 1 Table 7 *identifies schemes which support our planned change (including investment) into the delivery of* ***assessments and care planning*** *including how they are aligned with* key schemes/pathways mapped to the People Communities and Care model.

A joint approach to assessments and care planning				
PCC model Component	**Scheme Type**	**Existing BCF**	**New iBCF**	**1617 National Conditions**
CS	9. High Impact Change Model for Managing Transfer of Care	Managing discharges and Admission Avoidance	Managing discharges and Admission Avoidance	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn Transfers of Care
		Planned Care		
CS	10. Integrated care planning	Market Shaping and Stabilisation	Managing discharges and Admission Avoidance	Care Planning Invest in Out of Hospital Services Social Care Contn
		Planned Care	Service Pressures	
CS	11. Intermediate care services	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn
		Market Shaping and Stabilisation		
		Transformation		
PE	13. Primary prevention / Early Intervention	Managing discharges and Admission Avoidance	Service Pressures	Care Planning 7 Day Services Invest in Out of Hospital Services Social Care Contn
CS	14. Residential placements	Market Shaping and Stabilisation	Market Shaping and Stabilisation	Care Planning Invest in Out of Hospital Services
			Service Pressures	

Appendix 2

Table 9 identifies the stakeholder conversations held during the development of the People Communities and Care Model

Organisation / forum	Date		
Gateshead HWB	April 28	Joint integrated care board	March 23
Newcastle well-being for life	April 4	Gateshead transformation board	March 21
Newcastle people directorate	March 9	Gateshead MBC directorate	April 13
Newcastle portfolio holders	March 16	NUTH trust board	
Gateshead portfolio holders	April 24	NUTH integration group	March 8
Accountable officers meeting	March 31	Gateshead trust board	March 29
Sub AO meeting	March 2	NTW trust board	March 22
Newcastle task force	March 8	NTW transformation team	
CCG internal staff briefing	March 7	LMC/ CCG conversations	March 14
CCG corporate management	March 21	NG CCG governing body	March 28
Newcastle networks	May 16	Newcastle design lab	March 15
Gateshead VS leads	May 16	Newcastle GP federation	April
Vol sector open forum	May 16	Blue Stone consortium	April 26
GP forum	March 8	Estates group	March 13

Appendix 3 Current assessment of implementing High Impact Change Model (HICM) in Gateshead

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you measure Success?
Early discharge planning	Mature	Quarterly reviews of the SAFER bundle to ensure it continues to be effectively implemented	March 2018	Electronic Dashboard being piloted which will display live data at ward level to support proactive discharging. Roll out subject to review and funding. Electronic capture and Trust-wide report of EDD, currently monitor use and will start to report delay on date of EDD.
		Monitoring of EDD against actual discharge dates, including changes made during hospital stay	March 2018	Reduction in difference between planned EDD and actual discharge date.
		Integrated community teams to work with practices to identify people at risk of non-elective admission and ensure they have a coordinated plan in place	Ongoing - in place	Availability to view Emergency Care Plans and utilise them.
Systems to monitor patient flow	Mature	Introduce regular monitoring of capacity and demand issues across the system, including primary care and social care	Social care – already in place. Primary care October 2017 (to be in place for winter)	Reduction in admissions and improved system visibility of capacity
		Monitor reasons for delays to identify common bottlenecks	September 2017	Reduction in LOS for specific delays (overall average has potential to increase due to actively reducing avoidable admissions) / reduced number of stranded patients
		Work with services/ teams to develop more effective pathways/ processes to access resources and support which currently cause bottlenecks (e.g. equipment)	Deep dive into DTOCs via surge group during August. SAFER Programme planned for	Reduction in stranded patients i.e. LOS >6 days

			October.	
		Provide feedback to commissioners regarding any gaps in provision which cause bottlenecks	September 2017	Reduction in LOS. As above
		Ensure pathways in place to support patient flow – e.g. for palliative care and delirium	December 2017	Reduction in LOS. As above
		Ensure effective process around the use of section 2 and section 5, which does not cause delays in social care assessments	March 18	Reduction in LOS. SAFER Programme relaunch in October. LA GOSS system development to electronically refer.
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Plans in place	Ensure all partners attend ward/board round	October 2017	Effective Board Rounds focused on safer discharging. • Redesign of social care team in hospital (trial planned for August). • SAFER programme
		Develop proposals for the role of the voluntary sector within the discharge team/ process, including attendance at ward round	February 2018	Alignment of EDD and actual date of discharge No delays due to social circumstances
		Agreement of discharge pathways in which community teams have greater involvement in pulling patients out of hospital – linking in with the Unplanned Care model development and Integrated Teams Implementation Group to ensure this is built into plans	December 2017	Reduction in delays for transfer Reduction in stroke patient repatriations to hospital
		Development of a clear process for CHC assessments – linking in with CHC project group	Complete for Gateshead March 2018 for OOA	Reduce LOS by completing assessments outside of acute settings.
Home First Discharge to	Plans in Place	Agree role of integrated teams/ intermediate care/ reablement in supporting people to return home – linking in with the Unplanned	March 2018	Monitor as should see an increased proportion of patients admitted via

Assess		Care model development and Integrated Teams Implementation Group to ensure this is built into plans		non-elective route discharged to their usual place of residence within 7 days of admission.
		Support the development of the integrated service model for unplanned community services (including intermediate care and reablement) to ensure effective community support for discharge	March 2018	As above
		Ensure therapy provision is available to provide support at home – to prevent admission and support discharge – linking to the development of the Unplanned Care model. If gaps in provision will not be met through this new model flag issues with A&E Delivery Board and commissioners.	March 2018	As Above
		Work with care homes to establish their role in discharge to assess arrangements – linking in with Care Homes subgroup to ensure alignment to care homes plus scheme and developments led by commissioners	March 2018	As Above
Seven-day services	Plans in Place	Link to Unplanned Community services model to ensure coordinated support is available 7 days a week – if this will not be achieved by the new model, flag as issue to A&E Delivery Board and commissioners	March 2018	All partners to confirm ability to complete services 7 days per week; with updates required Dec 17 on progress.
Trusted assessors	Plans in Place	Joint agreement to be reached around the trusted assessors role – what can/ can't be put in place by who, agree processes with commissioning team	March 2018	Remove delays
		Ensure service restarts can be initiated by appropriate teams, to reduce the time taken to reinstate care and support at home – linking with commissioning/ brokerage team	March 2018	Remove delays
		Identify training needs for MDT members to complete trusted assessments, delivery of training	March 2018	Remove delays
		Trusted assessment role to be operational across agreed members of the MDT, with monitoring of appropriateness of care/ support put in place	Operational from April 2018, monitoring April – June 2018	Remove delays
		Agree shared assessment documentation for working with commissioners and providers of services	March 2018	Remove delays
		Single discharge plan to be developed for use by all teams, with agreed processes for sharing the plan with other agencies/ professionals	July 2018	Remove delays
Focus on choice	Mature	Training and communications for hospital and social care staff around setting expectations of patients and the strengths-based	March 2018	Reduced LOS

		approach		
		Agree standard use of choice protocol, with support from CCG and LA in following the protocol	December 2017	Reduced LOS
		Explore opportunities for greater involvement of voluntary sector, to be fully integrated as part of hospital and community teams	March 2018	Reduced LOS
Enhancing health in care homes	Mature	Care homes subgroup established – bring workstreams together (eg care homes plus, commissioner-led developments, links to community teams)	Ongoing - in place	Improve Patient Journey - system-wide working - reducing admissions
		Monitor care homes with highest non-elective hospital use and ensuring support is provided through primary care and community teams to reduce reliance on hospital	Ongoing - in place	As above
		All patients in care homes to have an Emergency Care Plan in place	Ongoing - in place	As above – no good if it can't be accessed
		Support care homes to review their policies/ support their staff, to manage greater complexity of need	Ongoing - in place	As above

Appendix 4 BCF schemes and iBCF schemes

Source of Funding	New Scheme	Original Scheme No.	Original Scheme Name	Scheme Value 2017/18	Scheme Value 2018/19
CCG Minimum Contribution	Managing Discharges and Admission Avoidance	1	Single point of access	360,000	360,000
		5	Expansion of Ambulatory Emergency Conditions (AEC) pathways	-	-
		8	Alignment of discharge support teams and coordination officers	725,000	725,000
		9	Expansion of intermediate care services	2,705,000	2,705,000
		11	Establish a seamless falls service	2,630,000	2,630,000
		N/A	Care Act	624,575	636,643
		N/A	Review Existing Service Portfolio Incl remaining Non Elective Activity	4,186,595	4,702,786
	Market Shaping and Stabilisation	9	Expansion of intermediate care services	453,000	453,000
		10	Expansion of the Gateshead Care Homes initiative	791,000	791,000
		N/A	Brokerage	124,000	124,000
	Planned Care	2	Alignment of District Nursing, Community Matrons, and Older People Nurse Specialists and RICC nurses + GP frailty register	56,000	56,000
		3	Elderly care coordinator / Alignment of frailty teams	714,000	714,000
		4	Enhance a seamless dementia pathway across Gateshead	61,000	61,000
		6	Establish a seamless palliative care service	-	-
	Transformation	7	Establish an urgent domiciliary suppport service	340,000	-
		9	Expansion of intermediate care services	-	102,000
		N/A	Post to support Data Integration and performance Analysis	80,000	80,000
	Carers	N/A	Carers	1,036,635	1,036,635
		N/A	Review Existing Service Portfolio Incl remaining Non Elective Activity	390,000	390,000
Local Authority Contribution	DFG	N/A	Disabled Facilities Grant	1,601,988	1,724,289
Improved Better Care Fund	Managing Discharges and Admission Avoidance	N/A	N/A	400,000	565,000
	Market Shaping and Stabilisation	N/A	N/A	2,750,000	4,590,000
	Service Pressures	N/A	N/A	2,300,000	2,155,000
	Transformation	N/A	N/A	472,645	730,219
Grand Total				**22,801,438**	**25,331,572**