Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

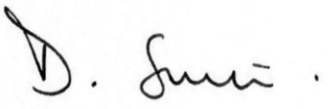
1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Sunderland City Council**
Clinical Commissioning Groups	**NHS Sunderland Clinical Commissioning Group**
Boundary Differences	**Co-terminus Boundaries**
Date agreed at Health and Well-Being Board:	**Initial Draft agreed on 14th February 2014;** **Progress update to Board on 21st March 2014;** **Chair sign-off of original submission 4th April 2014** **Chair sign-off revised submission 29th August 2014**
Date submitted:	**Resubmitted 29th August 2014**
Minimum required value of BCF pooled budget: 2014/15	**£12.052m**
2015/16	**£24.778m**
Total agreed value of pooled budget: 2014/15	**£24.348m**
2015/16	**£150m - £160m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group 	NHS Sunderland CCG	
By	Dave Gallagher	
Position	Chief Officer	
Date	29th August 2014	

Signed on behalf of the Council 	Sunderland City Council	
By	Dave Smith	
Position	Chief Executive	
Date	29th August 2014	

Signed on behalf of the Health and Wellbeing Board 	Health and Wellbeing Board - Sunderland	
By Chair of Health and Wellbeing Board	Cllr. Paul Watson	
Date	29th August 2014	

c) Related documentation

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

Document or information title	**Synopsis and links**
Better Health for Sunderland – Sunderland Clinical Commissioning Group **CCG 2 year Operational Plan April 2014-16**	**SCCG 5 yr Strategic Plan developed in 2012 (June 2014)** **Setting out the detailed proposals for delivery over the next 2 years in light of the new national planning guidance and the high level Strategic Plan on a Page**
Vision for 2025 – Sunderland City Council	Strategic commissioning plan for social care (and housing) within Sunderland, setting out the 5 aims of: Choice and Control

	Independent Living Improved Health and Wellbeing Equal Access for All Better Commissioning
Joint Strategic Needs Assessment	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities within Sunderland
Health and Wellbeing Strategy	The Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out within Sunderland
Intermediate Care and Reablement Strategy	Strategic document that sets out the landscape for intermediate care and reablement within Sunderland.
HWB Board Paper (November13) The Vision for Integration of Health and Social Care	Board paper describing the vision for integration of Health and Social Care and the five priorities to achieve the vision
Narrative/Vision Document re. Integrated Community Teams	Document describing the vision and ambition for Locality based integrated Teams in Sunderland
Accelerated Solutions Event 5th and 6th June 2014 – summary document	Document detailing work undertaken over the two days of the event
Fact Base for Sunderland June 2014 (produced by Oliver Wyman in collaboration with the CCG)	Risk stratification exercise based on GP Practice lists – locality based information

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Sunderland Joint Health and Wellbeing Strategy sets out the vision to have the:

Best possible health and wellbeing for Sunderland

….by which we mean a city where everyone is as healthy as they can be, people live longer, enjoy a good standard of wellbeing and we see a reduction in health inequalities*.*

The Design Principle within the strategy describe the need for:

'***Joint Working – shaping and managing cost effective interventions through integrated services***

Working together to make best use of our strengths and assets so that we can provide flexible and tailored services that respond to local conditions and focus on what matters to residents to achieve more for our communities.'

The Sunderland vision for integration identifies 5 priority elements within the Integration Programme:

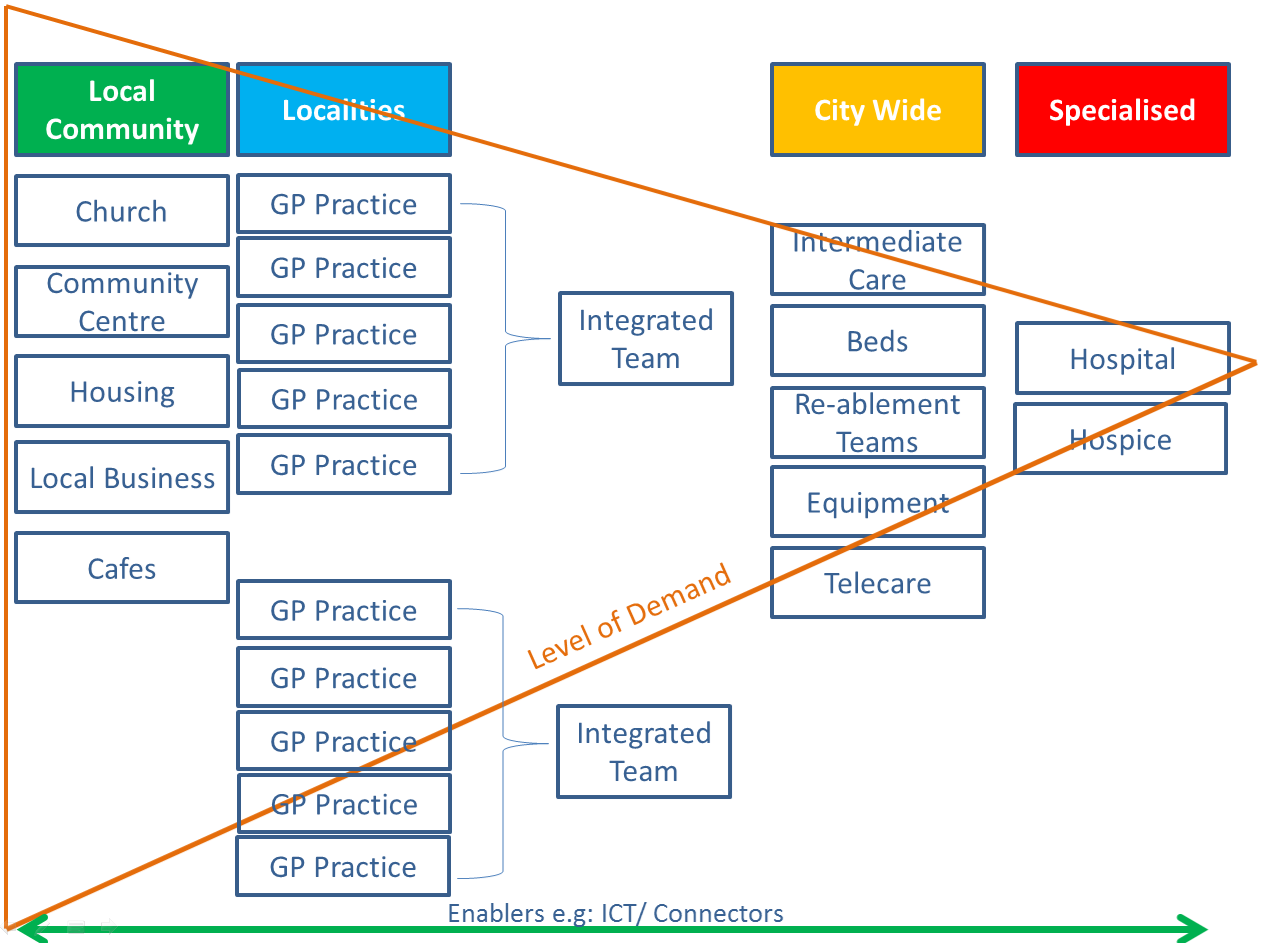
- An overall integrated operating model
- Locality integrated teams across health and social care
- Development of integrated commissioning processes
- Development of shared intelligence processes
- Development of enhanced user focus

Within Sunderland, a significant amount of work has been progressed to create the conditions for integration and alignment of resources at various spatial levels across the city. There is a strong track record of aligning resources towards certain targeted client groups, key outcomes and also at an area or neighbourhood level to better meet local needs (both formally and informally) and developing local responsive services.

This vision of transformation will be undertaken in full consideration and cooperation of provider organisations within the city as the expected outcomes of the transformations will impact significantly on both the operational services provided by those providers and their levels of activity/funding. A Sunderland Transformation Board has now been established with board-level membership from both commissioners and providers from across Health and Social Care. This will enable in particular the development of a whole economy strategic ambition and facilitate the consideration of organisational impact of proposed changes, and assessment and understanding of risks in respect of workforce and funding.

Building upon the work that has been progressed, the vision for integration in Sunderland lies in transforming the way health and social care works together. This requires truly integrated multi-agency working on an area footprint so that local health and social care systems work as a whole to respond to the needs of local people. It is about people being in control and being central to the planning of their care and support so they receive a service that is right for them, which in turn ensures a better quality of life.

In summary it is about Right Care at the Right Time for the Right People provided by people with the Right Skills. See diagram below of the overall operating model which is further explained in the following paragraphs.



The vision for integrated services will be built around bringing together social care and primary/community health resources into co-located, community focussed, multi-disciplinary teams, linking seamlessly into hospital based services (vertical integration).

At the heart of this programme is the commissioning approach which is focused on defined locality populations, rather than driven by a specific service. The populations will be the 5 Localities within Sunderland. The locality footprint is based on the 5 groupings of GP Practices across the city, with a population of ca 50,000 in each locality. These localities are deliberately co-terminus with the Council area regeneration and committee structures that have been in place for some time.

We intend, through commissioning to create multi-disciplinary teams that include all staff

who provide core community services in Sunderland e.g. all community nurses whatever profession or current specialist team; all GP Practice Nurses and Practice Teams; all community therapists and midwives, all social care teams and all community psychiatric staff.

Our vision is that these teams will be responsible for jointly planning, co-ordinating and delivering care to their Locality population. These teams we believe will be best able to identify and respond to individual needs and in so doing identify and resolve the current barriers that prevent a joined up response to the individuals within a Locality. They will also be supported to ensure they use their combined core and specialist skills to meet the needs of individuals and achieve better health and wellbeing outcomes than are currently being achieved.

The Better Care Fund is seen as a significant enabler to achieve the overall vision for health and social care in the City alongside other elements of the Health and Well Being Strategy.

b) What difference will this make to patient and service user outcomes?

The Vision is focussed on ensuring people who require health and social care services will experience:

- An integrated approach to assessing their individual needs – focused on their holistic needs not condition or context specific
- Care planning that is based on a single care plan which is owned by the individual and used by health and social care practitioners who are involved in their care, to ensure people only have to tell their story once.
- A co-ordination of their care and support, seven days a week, regardless of where their care and support is being delivered.

With this approach, people will be supported to better manage their health and social care needs, reducing the reliance on costly acute services, including avoidable admissions to hospital. If people do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission.

We will continue to invest in empowering local people through effective care navigation, peer support, mentoring and self-management programmes to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

At the heart of our vision for integration within Sunderland is the ambition to support individuals in crisis and help them to remain at home, through a rapid response reablement approach. This builds on the investment we have made into community resources across health and social care to work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication.

Within Sunderland, it is recognised that integration of health and social care services will include mental health services. Within NTW (MH Trust), there has been significant work to integrate pathways of care for people using their services. It is expected that where appropriate, mental health resources will be linked into the community integrated locality teams, especially in relation to supporting people with dementia symptoms and avoiding the need for admissions to residential care.

Equally we will be working with local communities to develop informal Community Connectors who will support the prevention and self- care agenda supported by a strategic approach to managing behaviour and demand.

To ensure the system we are working within, enables and not hinders, integrated care, the CCG and Local Authority will be commissioning jointly focussing on improving outcomes for individuals. The Joint Commissioning Group has been identifying the populations within Sunderland that would benefit from integrated commissioning, linking into the agenda for the Integration with Sunderland.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Over the next 5 years the Community Teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home. The Community Integrated teams will be organised around the GP Practices, placing the GP at the heart of organising and co-ordinating the care and support of people within their communities. The Locality Populations are formed from each GP Practice registered list. The registered list facilitates a long term relationship between individuals and their GP Practice; therefore it is the logical base on which to build integrated care, through the **Community Integrated Locality Teams.**

Our Teams will be co-located, community-focussed and multi-disciplinary in nature, recognising the need to work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Sunderland's overall aim for integrated care is to provide the right care and support to people in their own homes and communities through the development of the **Community Integrated Locality Teams** organised around GP practices, which ensures:

- Services are co-ordinated around individuals and targeted to meet specific needs
- Outcomes are improved for individuals
- Improvements in the care experienced by individuals, their families and carers
- Independence is optimised, by providing the right support in a timely manner, focusing on a reablement approach
- People have high-quality, tailored support which focuses on people staying out of hospital
- People's care is co-ordinated and managed, with the GP at the heart of organising the care, avoiding unnecessary admissions to hospital and care homes – enabling people to regain skills and independence after episodes of ill health and/or injuries.

Achieving this aim requires significant changes across the health and social care system, changes which have commenced and will continued to be progressed within future years.

From 2014/15….

We will continue the process of design, development and implementation of the **Community Integrated Locality Teams,** which means that we will be delivering person centred, co-ordinated care to supporting individuals in the co-delivery of their care and support.

The objectives of the Community Integrated Locality Teams are:

- Working together to identify those at greatest risk
- Developing joint plans for supporting individuals
- Working with individuals and their carers to deliver the plans
- Building capacity in the community to provide early and effective support
- Focusing on shared goals and outcomes

We **(CCG and Social Care commissioners)** will be commissioning and procuring jointly, focussed on improving outcomes for individuals within our communities through the co-location of commissioning resources across both organisations.

We will be focussing on **reducing unnecessary admissions to hospitals and care homes** through enhanced focus from the Community Integrated Locality Teams on having the ability to react in a timely, co-ordinated and consistent way when emergencies arise; applying a reabling approach to care and support within an individuals own home, optimising independence and regaining skills.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Sunderland recognises the achievement of our vision and delivery of the Health and Wellbeing Strategy requires change across the whole of the health and social care system. The development of the **Community Integrated Locality Teams** is one aspect of this whole system change and will change the way the professionals within these teams will work; however we will require all providers of health and social care services to work differently and further transformation change will be required to ensure whole system working. To deliver this ambitious agenda the Better Care Fund in Sunderland has been significantly increased in potential value to include all current LA/CCG spend on (initially) adult services 'out of hospital'. This will place in a number of agreed 'schemes' the resources required to deliver the required change and will enable full transparency of costs across health and social care enabling risks and potential efficiencies to be jointly managed where appropriate.
Many of these schemes will provide care closer to home and reduce the demand on hospital services for mental and physical illness and injury to improve care for individuals and to enable a shift of resources from the hospital setting to the community. The risks associated with this shift in resources from inpatient services to the community must be fully understood and the impact fully assessed in respect of current providers and their current activity and financial resources.

In preparation for 2015/16 we will in 2014/15 continue:

To Support People to Live Independently

We will use the 14/15 BCF as a catalyst to:

- Implement **Community Integrated Locality Teams** with the GP at the centre of organising and co-ordinating an individuals' care and support needs; as described the most ambitious of our proposed transformations utilising the combined health and social care budget of approximately £50m to deliver better quality outcomes for individuals and their carers whilst also creating up to £8m of efficiencies in reduced unplanned hospital admissions (modelled on implementing 'Torbay' model in Sunderland and sense checked with impact segmentation work and impact analysis from work with Oliver Wyman company). Non recurrent funding of over £5m has been identified over next two years to support this transformation.

- Provide care and support in people's own homes through provision of **home care and equipment** that promote reablement and independence; reviewing and if necessary enhancing equipment services in particular in respect of full accessibility to both prevent hospital admission and promote timely discharge.

- Support **carers** through investment in services that provide opportunities for breaks, information and advice to enable carers to continue their caring responsibilities; providing both continuity and enhancement of current carer support schemes including ongoing support to the Carers Breaks and Opportunities Scheme (CBOS) which has provided carers with an innovative and flexible option to support their caring needs.

- Continue investment in **Disabled Facilities Grants** to support people to continue living in their own homes

- Review services commissioned under existing section 256 agreement which **support people with dementia**, to ensure they are targeted to supporting people to remain safely in their own homes and communities; prioritising the completion of implementing the National Dementia Strategy in Sunderland, through investment in a range of proactive voluntary sector organisations to deliver schemes supporting individuals and their families at the point of early diagnosis and through early stages of the disease when more formal interventions are not indicated: this will complement the already well developed early diagnosis service provided by the Memory Protection Services and the comprehensive community and inpatient resources in place to manage the latter stages of the pathway.

Helping people recover from episodes of ill health (physical or mental health) or following injury

We will use the BCF in 14/15 to:

- Continue to invest appropriately in **reablement**, focussing on timely hospital discharges and reducing admissions to both care homes and hospitals where possible and appropriate

- Review services commissioned under existing section 256 agreement which **support people with mental health needs**, to ensure they meet the vision outlined within the plan for Integration

Reduce unnecessary admissions to hospital and subsequent readmissions within 30 days of discharge

We will use the BCF in 14/15 to:

- Invest appropriately in **Time to Think Services** which support people to recuperate after a hospital stay, enabling more joined up assessment of ongoing needs in an environment outside hospital and if appropriate prevent hospital admission occurring.

- Invest in supporting good quality care in **Care Homes** through provision of community nursing/clinicians, embedded within the locality integrated teams, who can work with Homes to provide appropriate interventions to people who would otherwise be admitted to hospital; this substantial investment in community services will develop from the current pilot programme in the Coalfields (2014/15) locality to become city-wide supporting people within both care home and supported living environments.(2015/16)

- Review and appropriately invest in **Sunderland's Intermediate Care Service**, which is focussed on supporting older people to regain/relearn skills following hospital stay or support people to get 'back on their feet' without need for a

hospital admission; in particular developing into a 24/7 alternative response to 'crisis' situations in an individual's living environment.

- **Strengthen whole-system 7 day working** to facilitate hospital discharges; reducing delayed discharges where possible; and considering what impact 7- day working or access would have on all services and where appropriate reconfiguring services and if necessary investing in services from 2015 to deliver 7-day accessibility.

Reduce admissions to care homes

We will use the BCF in 14/15 to:

- Support the extension of **Extra Care provision** across Sunderland, with a focus on supporting people with dementia to continue living in their own homes and communities.

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

We will use the BCF in 14/15 to:

- Invest in a **Personal Budget Support Service** for those individuals who want to direct their own care and support and require assistance to manage their social care or health budget

Systems will enable and not hinder the provision of integrated care

We will use the BCF in 14/15 to:

- Invest in **Voluntary and Community** provision within localities to support access to services that promote self management, peer support and reducing need on costly more acute services; recognising the need to mobilise the voluntary and community sector through appropriate and innovative grant schemes reducing reliance on statutory services.

- Review current spend including existing Section 256 and Section 75 agreements (these agreements contain current arrangements for the transfer of NHS funds to local authorities to deliver health outcomes and arrangements for the pooling of health and social care monies) against outcomes expected within the Vision for Integration

- Prepare plans for joint commissioning and provision in 2015/16, as per priority areas outlined above

- Introduce regular customer satisfaction surveying to develop our baseline for user experience

The next 5 years:

These transformational ambitions will deliver services to meet the challenge of the changing demographics within Sunderland in particular the increase in the elderly population. To grasp a greater understanding of the changing demography work has commenced in respect of identifying those at greatest risk of hospital admission due to their complex needs and of complications due to their LTCs in community settings – this segmentation of the population will inform the development of the community integrated teams. This work on risk stratification will continue and inform the development of live stratification 'dashboards' providing activity and demand information at a practice and locality level.

As described the Integrated Teams will be implemented in 15/16 supported by an extended intermediate care hub more able to respond to and prevent crisis admissions to hospital. Both programmes will be known to the newly procured Urgent Care Centres, A/E Hub and the Out of Hours Service and 111 to ensure the right support is provided at the right time in the right place.

The current locality pilot in respect of care in care homes will be rolled out to the whole of Sunderland in 15/16 providing robust support to care homes and their residents preventing unnecessary admissions to hospital and linked closely with end of life initiatives and is expected to become part of the integrated teams.

Any gaps between physical health services and mental health services will be closed with the full implementation of the transformational model for mental health including clear linkages between Mental Health and Long term Conditions.

The Dementia pathway in Sunderland will be fully commissioned in 14/15 with significant investments proposed within the voluntary sector to provide 'Dementia friendly communities' complementing the embedded early diagnosis services and comprehensive community teams and inpatient provision.

b) Please articulate the overarching governance arrangements for integrated care locally

The Health and Well Being Board within Sunderland has agreed to the establishment of the Health and Social Care Integration Board to oversee the delivery of the vision, which is made up of Senior Officers within both the CCG and LA. The Board will ensure the work programmes are aligned to the Vision for Integration and sound governance arrangements are in place. An Out of Hospital Transformation Board has also been established with partners to steer delivery of the out of hospital transformation and in particular to ensure delivery of the related programmes mentioned here which impact on the same population of complex patients and will lead to the £8m efficiency from the acute sector. e.g. integrated teams; intermediate care; end of life; care homes and dementia friendly communities. The Board is supported by an Operational Group to ensure synergy of operations with multi agency steering groups for each transformation programme to ensure delivery of the programme.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The Joint Commissioning Group, alongside the Joint Commissioning Unit (CCG and Social Care Commissioners) will oversee the use of the pooled budgets reporting to the Integration Board and will facilitate the delivery of the BCF. A Sunderland Transformation Board has also been established bringing together all organisations, both commissioners and providers, into a single Executive Level Board; enabling in particular consideration of the organisational impact of proposed changes and assessment/ understanding of risks across organisations and what this means for the **whole system** in Sunderland. The Board will also be expected to sponsor the key transformational programmes and facilitate the resolution of any issues which may put any of the programmes at risk.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Community Locality Integrated Working
2	Intermediate Care/Reablement
3	Packages of Care – Care Homes
4	Packages of Care – Home Based
5	Supporting Carers
6	Learning Disabilities

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Operational pressures will restrict the ability of our workforce to move to Community Integrated Teams impacting upon the vision, outlined in our BCF submission turning into a reality.	3	4	12	Vision for Community Integrated Locality Teams is premised on the understanding that investment and support from clinical and managerial leaders is required -especially in relation to allowing frontline staff time and space to develop as locality teams – non-recurrent resources have been identified and secured to release a number of key operational leaders across health and social care organisations
Shifting of resources to fund new joint interventions and schemes will destabilise current service	2	4	8	Continual engagement with providers via Transformation Board, Provider Forum, Board Level and Director-Director dialogue, Provider

providers, particularly in the acute sector.				management Meetings – contract/quality. Provider membership of Programme Boards and clinical engagement within work programmes and model development The consequences of the changing future state will be managed collaboratively and transparently with providers enabling comprehensive financial, workforce and quality impact assessments to be undertaken.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting on the overall funding available to support core services and future schemes.	3	4	12	Monitoring processes via the Out of Hospital Board, the Joint Commissioning Group and the Integration Board. Substantial non-recurrent funds available to pump-prime and support transformation. Development of benefit realisation metrics; alongside the transformation programmes – to monitor quantitative and qualitative changes
The introduction of the Care Act will result in a	5	3	15	Work is underway to fully understand the implications of the Care Act within

significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans				Sunderland supported by a dedicated programme board. Financial impacts have been modelled based on Lincolnshire Model – with pooled budgets being proportioned to reflect the impacts as currently known. Plans for Integration will continue and the Health and Social Care Integration Board will continue to monitor the impacts as the Care Act is implemented

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

In relation to the risk sharing arrangements, for health and social care, the pooling of all out of hospital (NHS) and Adults (LA) monies within the overall BCF, allows for the joint management of the financial risks across health and social care Significant impact in subsequent years if improvement is not achieved which will result in re-profiling of pooled budget; this risk is reflected in the contingency plans within the financial strategy of the CCG, however if required to be called upon would necessitate a re-profiling of current investment plans. The CCG has unallocated growth monies within the scheme. CCG Financial planning over next five years recognises that activity, if unchecked, may rise by 1.5% each year resulting in £9m. risk to the organisation. This risk is reflected in the contingency plans within the financial strategy of the CCG, however if required to be called upon would necessitate a re-profiling of current investment plans.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

As outlined in Sections 2, 3 and 4, the BCF in Sunderland reflects our overall ambition for Integration and therefore is linked with all out of hospital care and support programmes underway.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

BCF plan are integral to both the 2 year operating and 5 year strategic plans – all describing the ambition for integration across health and social care; and expected outcomes.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Sunderland CCG has applied for primary co-commissioning status. Current proposals are being developed with primary care in relation to £5 per head funding and additional CCG funding to be utilised by GP Practices and Localities to support key building blocks in the development of community locality teams.

Funding has been identified within the BCF to support the primary care input into out of hospital care. All Practices have contributed to the discussions on development of community locality teams via a series of development and engagement events including all 53 GP practices. GP Executive Board Leads and Clinical Leads have contributed significantly to the thinking behind the development of integrated teams.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting Sunderland's social care services means ensuring that those in need of social care support continue to receive the support they require, against the back drop of increasing demand (demographic pressures and increasing levels of need) and significant budgetary pressures.

A primary focus is working with people at the earliest opportunity to prevent people requiring more costly on going services, through the provision of information and short term interventions to support people to manage their own well-being for as long as possible.

Enabling people to stay safely within their own homes and communities for as long as possible, protecting and enhancing quality of life is at heart of protecting social care services.

The implementation of the Care Act provides Sunderland with an opportunity to adopt the national eligibility criteria; we currently operate across all 4 FACS Bandings within the Eligibility Criteria. The future operating model will focus on a range of low level preventive interventions and Information Advice and Guidance offer for those customers previously in low and moderate bands.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The allocation from the NHS for Social Care Grant has been used to enable Sunderland City Council to sustain current levels of social care services, in relation to social work functions and commissioned services, especially those services which provide care and support in the Home (home care), services which facilitate discharges (reablement and Time to Think) or focus on quality of care within Care Homes (Care Home Quality Standards Fees)

These monies will need to be sustained at a minimum within funding allocations for 2014/15, if the level of support is to be maintained. The implications of 7 day working will need to be considered; alongside the consequences of the Care Act, which place additional requirements on social care. For example, the requirement to put carers on par with individuals in relation to assessments, establishing statutory Safeguarding Adults Board, and implementing the national eligibility criteria. The NHS for Social Care Grant is enhanced by £1.5m in 14/15 and will support these requirements – this amount generally equates to the recently published indicative impact of the Care Act on Local Authorities (0.8m).

In addition the integration of health and social care teams will potentially lead to consequential efficiencies in ways of working however this will require robust modelling in relation to consideration of expected increase in demand.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

As the BCF in Sunderland includes all out of hospital (NHS) and adult monies (LA); the amount of £0.8m has been proportioned across all 6 pooled budgets to reflect the increased requirements for social care based on Care Act implementation

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The new duties will be met through the Community Locality Integrated Working Scheme; which will see the needs of self-funders, those with eligible needs and their carers receiving appropriate information and advice, preventative offers and on going support if required, in line with Care Act statutory guidance.

v) Please specify the level of resource that will be dedicated to carer-specific support

One of Sunderland's Schemes is 'Supporting Carers' and level of resource dedicated is in excess of £2.5million, demonstrating the commitment Sunderland has in supporting carers to maintain their caring responsibilities, alongside their own health and well-being

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

No change due to the BCF reflecting total social care spend for adults.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The Health and Wellbeing Strategy identifies the main areas where integration will improve outcomes. The Transformation Board will oversee the strategic commitments in relation to seven day health and social care services.

Work has commenced to develop 7 day health and social care service across Sunderland, supporting people in relation to discharges from hospital – there are social work, therapy and health staff who are working over 7 day period within the acute sector.

Rapid response home care services have been introduced to facilitate discharges over 7 day period and to prevent unnecessary admissions at a weekend.

These developments have been funded by monies identified to support the Reducing Readmissions Programme and Winter Pressures, which is currently being evaluated.

The local acute trust has employed 2 staff to consider the requirements for the acute trust and the CCG will be asking the multi agency transformation board to extend this work to all Providers and oversee the delivery of this programme across all providers. The developing pan Sunderland GP alliance will also be invited to be members of the Board to ensure a whole system response.

Non recurring funding is available to support this transformation.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All health services use the NHS number as the primary identifier in correspondence.

Sunderland City Council has the ability through their Adults Information System to record the NHS Number, with many of these already recorded.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open APIs and Open Standards. Discussions have commenced regarding the accessing systems and data. Within Sunderland, we already use:

- System One, a clinical computer system that allows service users and clinicians to view information and add data to their records;

- Emis Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record;

- Meditech – computer system used within the acute sector, which is also accessed by social work resources, supporting hospital discharges.

- AIS, a database for managing social care cases

- NHS Net Accounts – for secure emails

- GCSX – for Council secure emails

In order to embed the Community Integrated Locality Teams and facilitate the organisation of people's care and support, we are committed to improving the interfaces and security between systems

All our GP practices use the same IT system, providing the opportunity for our care providers to all use the same patient record; the BCF will help ensure this happens by joining up Health and Social Care data across Sunderland, linked as above via the NHS number.

We will also be working with Palantir, our Strategic Partner who has been procured by the Council but for the city to develop an Intelligence Hub – an approach to transforming data into intelligence and using it to solve problems. One of the key problems the hub is expected to help us solve is that of shared records to support integrated teams taking account of appropriate information governance safeguards.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

There is a commitment to develop an Information Governance framework for Integration, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

Confidential information about service users or patients should be treated confidentially and respectfully

Members of a care team should share confidential information when it is needed for the safe and effective care of an individual

Information that is shared for the benefit of the community should be anonymised

An individual's right to object to the sharing of confidential information about them should be respected

Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

Past experience of a Single Assessment Process across Health and Social Care has proven the benefits which need to be considered in this future development.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Sunderland CCG is working with a company funded by NHS England to identify those populations at most risk of hospital admissions, with a view to those individuals having a lead professional to plan and co-ordinate their care.

The outcomes of this work between the CCG and Oliver Wyman Co. has now been concluded (See associated key documents) resulting in greater understanding of the segmentation of the population and its risk profile across and within localities. The single key message is that 3% of our population account for 50% of our health and social care spend and will be the initial focus for our integrated teams

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Within our acute trust, City Hospitals Sunderland, the LACE predictive tool is being used to identify those individuals who are at risk of readmissions, looking at both health and social care factors.

The Directly Enhanced Service for risk profiling has been implemented and will also inform the community integrated locality team development, supplemented by the Oliver Wyman work on segmentation and risk profiling noted above.

The CCG has also ensured the £5 a head for over 75s has been protected in the budget and will form part of the BCF to be used to support the Practices in delivering their contracted responsibility to have an accountable GP for over 75s and complex patients, managing their care. The CCG also intends to work with the Area Team to deliver the new directly enhanced service for avoidable admissions as this will support the joint assessment and accountable lead professional requirements

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Through the risk stratification process, each Practice has identified their patients within the high risk category, as outlined above. This will inform the development of locality integrated teams which in turn will hold the joint care plans for individuals at high risk. At this stage, these formal joint plans are yet to be put in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Integration of health and social care services within Sunderland is based on a vision that has been formed by what people of Sunderland have told us that they want from health and social care services. There is a desire amongst people in Sunderland for a safe, integrated, effective and timely response that meets their individual needs.

People want choice and control, support to continue living in their own homes and communities with services that are co-ordinated to meet their individual needs at times which they require. At the heart of the vision is the ambition to deliver the right care and support, at the right time in the right location with the right people to meet the needs of the individuals, their carers and families living within Sunderland.

Within the Person centred Co-ordinated Care Partnership established to oversee the Integrated teams development, engagement with HealthWatch Sunderland has been progressed and Healthwatch have included the Integration Agenda in Sunderland on their work programme for 14/15. Now the integrated teams work is part of the overarching Out of Hospital Transformation Board, Healthwatch continue to have a key place on the Board.

Within Sunderland there is a rolling programme of Local Engagement Board events through which particular issues/ proposals are shared and discussed with the public. Throughout the development and authorisation of the Clinical Commissioning Group topics relating to the need to improve coordination and integration of community services have been raised and discussed at these events.

A specific ‘Call to Action’ event bringing together service users and the public with service providers and commissioners highlighted and reinforced the need to enhance the integration of health and social care.

Engagement events have gathered narratives from service-users and carers to inform the development of the transformation initiatives in particular the need for 7-day access to services and initiatives to tackle the public perception of community services and organisations that are disjointed and not working together.

The Accelerated Solutions Event described above engaged with a range of Voluntary Sector, patient and carer organisations and using specific personas, participants began to build intent for and clarity on what needs to be different for Health and Social Care across the City. The personas were based on real experiences and people within Sunderland.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The plan for Integration and Better Care from Sunderland reflects a number of programmes that have been developed with partners, which includes NHS providers, Social Care Providers, Voluntary and Community Sector, alongside people who use services, their carers and families.

A formal governance structure has been developed which is described within this submission to ensure full engagement with statutory organisations across health and social care.

See event details below for engagement with trusts

ii) primary care providers

Out with these formal arrangements a range of engagements have taken place across the city in relation to the programmes within the plan for Integration within Sunderland:

- Within the NHS 'Call to Action' process there have been a number of Engagement Events to inform the CCG Planning Process; feedback from these events identified the need for integrated care, throughout the whole life course, care that is co-ordinated to meet the outcomes that are important to people, their carers and their families.

- On the 14th May a half-day 'Learning with Lunch' event brought together all 53 GP Practices in Sunderland with partner organisations, patients and carers:

(Extract from formal report following event)

Introduction

SCCG Executive and Sunderland Council wish to outline the context, vision and approach to commissioning community services over the next 5 years, along with the design principles that will guide the final provision of services.
Our public, member practices, Councillors, co commissioner in the Area Team, along with the current providers of community services will be well aware of the value of community based services in supporting people in the community, helping to regain/maintain their independence and supporting their overall wellbeing. Equally they will be aware of the challenges in Sunderland, including the myriad of current provision, fragmentation, increasing numbers of older people and over reliance on hospital care. We are all very aware of our patient/resident desire for a safe, integrated, effective and timely response that meets their individual needs.

SCCG from its inception has been passionate about tackling these challenges and bringing greater value to all. The Council has also been ready from our inception to join with us in addressing these challenges for a population which we share. We will achieve this by a different commissioning approach, ensuring we commission in a way that

achieves the outcomes we are seeking and results in the services people actually need and prefer…

…We intend, through commissioning to create multi-disciplinary teams that include all staff who provide core community services to both children and adults in Sunderland e.g. all community nurses whatever profession or current specialist team; all GP Practice Nurses and Practice Teams; all community therapists and midwives, all social care teams and all community psychiatric staff.
Our vision is that these teams will be responsible for jointly planning, co-ordinating and delivering care to their Locality population. These teams we believe will be best able to identify and respond to individual needs and in so doing identify and resolve the current barriers that prevent a joined up response to the individuals within a Locality. They will also be supported to ensure they use their combined core and specialist skills to meet the needs of patients and achieve better health and wellbeing outcomes than currently…

…There are no legal and statutory barriers to this vision. The evidence base behind this approach tells us that the most important factors are a shared vision and a shared desire to make it happen. We believe that providing a clear leadership approach to commissioning and a supportive environment for frontline staff, will make integrated locality teams based on the above design principles a reality. This is our vision and we will commission from Providers who share our vision and will help us deliver better care and better outcomes for the population of Sunderland.

Event Overview

The event was held at the Stadium of Light in Sunderland with 314 delegates attending representing the following organisations:

- *53 Member GP Practices*
- *Action on Hearing Loss*
- *Age Uk*
- *Carers Association*
- *City Hospitals Sunderland NHS Foundation Trust*
- *EMIS*
- *Gentoo*
- *Healthwatch*
- *HOPS Wellbeing*
- *Locality Patient Participation Groups*
- *Members of the Public*
- *Northern Sign*
- *Northumberland, Tyne & Wear Mental Health NHS Foundation Trust*
- *Oliver Wyman*
- *Parkinsons UK*
- *South Tyneside NHS Foundation Trust*
- *Sunderland Carers Centre*
- *Sunderland City Council*
- *Sunderland Clinical Commissioning Group*
- *Sunderland People First*
- *Thornbury Care Home*
- *Thornhill Park*
- *Young Minds*

iii) social care and providers from the voluntary and community sector

On the 5th and 6th of June, the CCG, together with the City council and the Health and Social Care Integration Board held an ASE (Accelerated Solutions Event) taking the lead with partner organisations across health, local government and the voluntary sector to develop an ambitious programme to address the long standing health and social care issues in Sunderland. The aim being to further develop the Health and Social Care Integration agenda and create a shared understanding and commitment to how the agenda will be delivered.

One hundred participants focussed on 'delivering Better Health and well-being for Sunderland' over two days of intensive, collaborative working; they shared their experiences, learning and aspirations to develop the future of Sunderland.

The objectives that were collectively achieved by the participants were:

- Reaffirm the vision and outcomes for Sunderland and the financial context in which this needs to be delivered.
- Understand and define how Health and Social Care Integration Agenda will support the achievement of these outcomes over the next two years.
- Discuss and shape a tangible plan that will take us forward in the short, medium and long-term including agreement on how to measure success.
- Engage all key stakeholders in the programmes to gain feedback on proposed service changes and identify how we will work together to drive greater quality, value and sustainability.

One hundred participants were focussed on 'Delivering Better Health and Wellbeing for Sunderland' over two days of intensive collaborative working.

The developing plan has also been shared and considered on a regular basis via our multi agency Transformation Board established to oversee delivery of the system wide 5 year Strategic Plan and the Provider Forum established as an advisory body to the Health and Wellbeing Board.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The transformational shift of activity from the Acute Sector to community based options will impact most on the business activity of the local provider of acute services; City Hospitals Sunderland.
This potential financial and activity impact has been modelled. Further work is on-going to determine the likely organisational impacts including the workforce impact. This will require continuous monitoring and evaluation throughout the transformation period to

ensure any potential destabilising effect on the provider is understood and managed. Consideration is also needed on any impact on North East Ambulance Service.

The revised guidance on the 3.5% reduction was "mandated" on non-elective activity for the BCF; however states that there could be a case for CCGs to set a lower ambition but as long as it is a stretching and ambitious target based on 6 criteria:

1. The position from which the area is starting; eg an area which has already achieved top quintile performance in reducing emergency admissions may not be able to achieve further improvements as extensive as an area in the lowest quintile; the local trend in performance; ie is the area improving or worsening on this metric;
2. How current performance compares to peer areas; and
3. Whether the local population is projected to increase by more than the national average.
4. A plan which sets an ambition lower than 3.5% in 2015/16 must explain how the planned level of improvement will contribute to a longer term trajectory of reduction linked to the transformation of local health and care services.
5. Any revised ambition lower than the assumed 3.5% must have the explicit support of the Council and all of the CCGs who are party to the plan, and must have the explicit written commentary of acute providers (in annex 2 of the Part 1 template).
6. Each area should ensure that the contingency plan and risk sharing agreement make prudent provision for the costs of unplanned activity if emergency admissions are not reduced in line with the plan. The lower the planned reduction, the less money will be available through the payment for performance element of the Fund, and more will need to be invested in NHS commissioned out of hospital services

In Sunderland we have agreed with partners a target of 0.8%. Our rationale is:

1. In Sunderland we have seen a reduction in non-electives in 13/14 which is continuing into 2014/15. We are not in the top quintile but are showing a significantly improved position.
2. In comparison to peers, particularly those in the North East, we are between the 2nd quintile so very much showing that improvement but also "better" than others. Looking more broadly at City Hospitals Sunderland NHS FT in comparisons with their national peers, a similar position so suggests that we are already improving against our peers and lower in most cases.
3. Although our local population is not projected to increase by more than the national average over the next 10 and 20 years in total, ages 65+ are projected to increase in Sunderland by a larger percentage over the next 10 years compared to the England average. This cohort of patients the most likely to be admitted as a non-elective admissions. This has formed some of the basis around Integrated Teams and our ambition to reduce emergency admissions from 16/17 onwards by 15%.
4. By setting our ambition (0.8%) for the BCF in line with the ambitions within the Operational Plan, the plans are now completely aligned to our strategy and our 5 year strategy has the longer term goal of 15% reduction from 16/17 onwards.
5. This is part of our BCF submission.
6. We have a plan in place to meet this requirement.

Recurring growth investment over years 1 and 2 in out of hospital care will support this transformational change complemented by additional use of non-recurrent funding.

A Transformation Board has been established with board-level membership from both commissioners and providers from across Health and Social Care. This will enable in particular the development of a whole economy strategic ambition and facilitate the consideration of organisational impact and risk management of the proposed changes along with the impact of recent contract negotiations and the current and proposed tariff efficiencies. Specific engagement will also take place with providers who through their active membership of various transformation work programmes and via the new Out of Hospital Transformation Board will gain full understanding of the implications of the future state for health and social care; the consequences of this changing future state will be managed collaboratively and transparently with providers enabling comprehensive financial, workforce and quality impact assessments to be undertaken.

As highlighted above specific financial and activity modelling has already commenced utilising tools made available through the 'Anytown' toolkit and the Local Government Association modelling tool. The use of this modelling has been described to providers in particular the potential impact of fully operational integrated teams supported by 24 hour access to intermediate care and reablement; end of life care and improved quality of care in care homes as described in the Torbay model – this suggests for example a £7.9m reduction in Sunderland in non-elective activity in the acute sector. Further work will be undertaken to further test and refine this initial modelling with full inclusion of providers. Assurances have been given to the Acute provider in Sunderland that this expected change in activity will be closely monitored and should activity levels not decrease they will not be financially disadvantaged.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCF 1
Scheme name
Community Locality Integrated Working
What is the strategic objective of this scheme?
We intend, through commissioning, to create multi-disciplinary teams that include all staff who provide core community services to those of the population with the greatest need irrespective of age. The most ambitious of our proposed schemes is utilising the combined health and social care budget of approximately £50m to deliver better quality outcomes for individuals and their carers whilst also creating up to £8m of efficiencies in reduced unplanned hospital admissions (modelled on implementing 'Torbay' model in Sunderland). Non recurrent funding of over £5m has been identified over next two years to support this transformation.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Our vision is that Integrated Community Locality Teams will be responsible for jointly planning, co-ordinating and delivering care to their Locality population. These teams will be best able to identify and respond to individual needs and in so doing identify and resolve the current barriers that prevent a joined up response to the individuals within a Locality. They will also be supported to ensure they use their combined core and specialist skills to meet the needs of patients and achieve better health and wellbeing outcomes than currently. The planned outcomes are: • Reducing emergency admissions by 14% by 2019 • Reducing emergency readmissions by 14% by 2015 • Improve patient experience of out of hospital care by 8% by 2019 • Supporting people to live at home • Reducing the number of people admitted to long term residential/nursing care. • Improving the diagnosis rate for dementia • Increasing the number of people with depression referred for psychological therapies • Ensuring achievement of A/E 4 hour waits
The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Sunderland CCG has taken a partnership approach with South Tyneside Foundation Trust, Sunderland City Council, Northumberland, Tyne and Wear NHS Foundation Trust and Sunderland City Hospitals and NHS England to create the Person Centred Co-ordinated Care Partnership. The partnership have agreed the design principles underpinning the team approach include:

- Patient, carer and family at the centre of care planning and decision making
- Patients as co-producers of their care and outcomes
- All ages – children and adults
- High quality care for all unplanned and planned needs
- Delivering care that provides value for money
- High performing teams with appropriate leadership, development and resources irrespective of staff employment status or employer

In addition the characteristics of the model have been agreed e.g. care co-ordination; self care; single point of contact in each Locality; wrapped around practices. These characteristics are based on evidence of what has worked across the country and internationally. See references:

Project Group includes:

Sunderland City Council, Sunderland CCG, South Tyneside Foundation Trust, Sunderland City Hospitals Foundation Trust, Northumberland, Tyne and Wear MH Foundation Trust, Primary Care/GPs, representatives from VCS.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

LGA Value Case for Co-ordinated Health and Social Care
House of Care Framework for Integrated Care – NHS England
Future Forum Report and the 6 models including the Oliver Wyman model re extended primary care and extensivists
Anytown Tool and High Impact Interventions and Early Adoptors

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The planned outcomes are:

- Reducing emergency admissions by 14% by 2019
- Reducing emergency readmissions by 14% by 2015

- Improve patient experience of out of hospital care by 8% by 2019
- Supporting people to live at home
- Reducing the number of people admitted to long term residential/nursing care.
- Improving the diagnosis rate for dementia
- Increasing the number of people with depression referred for psychological therapies
- Ensuring achievement of A/E 4 hour waits

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The partnership approach ensures that all plans and outcomes align to ensure a system wide approach and inparticular the Out of Hospital Board and its Operational Group which will steer the creation of synergy from the various programmes or parts of the pathway to ensure a joined up response for patients with complex needs. For example the role of the city wide intermediate care service in supporting the work of the locality based integrated teams.

What are the key success factors for implementation of this scheme?

A key success factor is to ensure the data on the patient population (both Oliver Wyman segmentation triangulated with the Practice DES data, soft intelligence and the reaons why patients are turning up as emergency admissions) is used intelligently to inform the make up of the integrated teams ie. That the teams are built on the basis of being patient centric and will work with a complete patient centric focus.

Another key success factor is to have clinical including GP Practice and multi agency engagement in the design of the teams and we have ensured there is resource to support the secondment of clinicians from each agency into the design teams over the longer terms.

Scheme ref no.

BCF 2

Scheme name

Intermediate Care and Reablement

What is the strategic objective of this scheme?

To develop a locality focused collaborative model, which maximizes independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self-care and self-management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.

High Level Aims include:

- Maximising independent living
- Promoting faster recovery from illness
- Minimising admissions to long term residential care
- Facilitating a timely discharge from hospital
- Providing effective alternatives to hospital admissions

A key objective is:

We will coordinate access to intermediate care services, ensuring a rapid response is available where appropriate

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Key activities include:

- Ongoing development of an 'Intermediate Care Hub' to provide a single point of access and streamlined referral to intermediate care services
- Develop clear referral pathways into the Intermediate Care Hub with standard documentation, for hospital, community and primary care
- Review and further develop the rapid response component of the intermediate care model to provide urgent community based assessment and intervention in people's homes
- Develop a standard process for GP admissions, ensuring alternative pathways are readily available for individuals via the Intermediate Care Hub if a hospital admission can be prevented
- Analysis of the demand for intermediate care services over a 24 hour period to enable demand to be matched to capacity/availability

Current situation

The Intermediate Care Hub (IC Hub) was formally established in June 2012 and provides a single point of access to intermediate care services. The IC Hub is supports the following pathways:

Step Up/Admission Avoidance – *to support individuals to remain in their usual place of residence wherever possible. This pathway may be appropriate for:*

- Individuals in the community experiencing an acute episode of illness or exacerbation of pre-existing condition or illness
- Individuals who do not require the level of medical intervention of an acute hospital but may require nursing, therapy and/or medical assessment in their own home or a bed based service (rapid assessment within 2 hours where appropriate)
- Individuals who would benefit from rehabilitation/reablement either within their own home or a bed based service

Step Down/Facilitated Discharge – *to support individuals to return home or to an alternative environment appropriate to their needs. This pathway may be appropriate for:*

- Individuals who are medically stable following an episode of acute hospital care (for illness and/ or surgery) but may require further medical, nursing and rehabilitation/reablement either within their own home or a bed based service

Virtual communication links are in place with Discharge Nurses, acute ward teams, Hospital/Community Social Workers, the Community Rehabilitation Team and the Community Occupational Therapy Service.

The Intermediate Care Hub currently operates from 8am-8pm Weekdays and 9am-4pm Saturday and Sunday which is when the vast majority of referrals are anticipated. However out of hours arrangements differ and access to certain services has proved a challenge.

There is a need to move beyond services alone when developing intermediate care to concentrate on the whole health and social care system. This is to ensure that fragmentation and dislocation in the patient experience is minimised as people move between multiple service providers. The current hub service does not operate 24 hours per day. Having different arrangements at different times of day compounds the problem of care fragmentation. Confusion about who and where to contact for support to help care for people at home often results in a default to the easiest option – A&E attendance or hospital admission.
The proposal is to build on and develop the existing service to provide a 24 hour single point of contact for co-ordination of multi-agency and multi-disciplinary care, that is driven by people's needs rather than service set up.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Project Group includes:
Sunderland City Council, Sunderland CCG, South Tyneside Foundation Trust, Gateshead Foundation Trust, Sunderland City Hospitals Foundation Trust, Northumberland, Tyne and Wear MH Foundation Trust and Sunderland Care and Support (Local Authority Trading Company).

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

It is vital to offer rapid responses in the community that offers an alternative to hospital stay and this provision needs to be person focussed. Currently the team is virtual

resulting in fragmentation of communication, and there is no shared plan of care. There is also a need to strengthen links with some services, such as mental health Rapid Assessment Interface and Discharge (RAID) services, which are proven to reduce hospital bed use, particularly for older people (p11, Evidence Summary - Making Better Use of the Better Care Fund,)

In addition there is a need to eliminate the confusion over who to contact out of hours, therefore reducing unnecessary A&E attendances and hospital admissions. With intermediate care, provision has historically tended to concentrate on supported discharge, and this is reflected in the use of the hub at present. There has been much less of a focus on admission prevention and avoidance. The introduction of a 24 hour a day 'super hub' will start the shift of this focus and truly provide patient centred alternatives to hospital admission.

In our local Emergency Care Intensive Support Team (ECIST) report from 2012, it is identified that there is over and underutilisation of some teams. Setting up the multi-agency and multi-disciplinary team proposed for the hub would provide the opportunity to rationalise services. ECIST also commented on Sunderland's cultural reliance on beds, reinforcing a perception among both patients and professionals that beds are what constitute safe or proper care. This also drains resource available for home based services such as reablement and rehabilitation. In light of this, a review of the beds commissioned across Sunderland is imminent, and it is anticipated that a reduction in beds will be made. It is imperative that we increase the availability and uptake of home based care provision to enable this to occur, and the super hub would be crucial in achieving this aim.

References

Transforming our health care system. The Kings Fund. April 2013
'The billion dollar question': embedding prevention in older people's services – 10 'high impact' changes. University of Birmingham. August 2010
Integrating health and social care in Torbay. The Kings Fund. March 2011

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

By April 2016

- Elimination of confusion – right person, right time, right place
- Improved quality of care and patient experience (Torbay satisfaction 48% – 100%)
- Improved response times (e.g. Physio 8 weeks to 48 hours Torbay)
- Lower hospital death rates (Torbay 44.6%, national 58%)
- Reduced emergency admissions to hospital
- Reduced re-admission to hospital

By April 2018

- Improved access to reablement - shown to reduce the need for homecare by 28% and can delay the need for up to 1 year – Birmingham university – The billion

dollar question….10 high impact changes)

By April 2021

- Reduced residential and nursing home placements (dropped by 31% in 8 years in Torbay)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Via the Out of Hospital Board

What are the key success factors for implementation of this scheme?

Anticipated successes:

- Elimination of confusion – right person, right time, right place
- Improved quality of care and patient experience (Torbay satisfaction 48% – 100%)
- Improved response times (e.g. Physio 8 weeks to 48 hours Torbay)
- Lower hospital death rates (Torbay 44.6%, national 58%)
- Reduced emergency admissions to hospital – Kings fund
- Reduced re-admission to hospital –
- Improved access to reablement - shown to reduce the need for homecare by 28% and can delay the need for up to 1 year – Birmingham university – The billion dollar question….10 high impact changes)
- Reduced residential and nursing home placements (dropped by 31% in 8 years in Torbay)

An alignment of services from 17.30 until 10pm will be completed by October 2016.
24 hour operation will be in place by march 2016.

Scheme ref no.
BCF 3
Scheme name
Packages of Care – Care Homes
What is the strategic objective of this scheme?
Improve the quality of health care in Care Homes across the city via an enhanced primary and community proactive approach for residents of residential, nursing and extra care, thus addressing current inequality of access to healthcare.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The overarching aim of the scheme is that *Residents and their families will feel better cared for.* Main achievements will be: • Residents and their families feeling better cared for • Implementation of 'Deciding Right' to support end of life wishes • Development of Emergency Healthcare Plans (EHCP's) • Quality assessment carried out in nursing homes and training needs identified The scheme provides enhanced health care to residents from a multi-disciplinary team, involving partners from Primary Care –GPs, Community Services, therapy services from Acute and Community services, Community Geriatrics, pharmacy from Independent Sector, Local Authority Social work. Care Home providers are fully engaged in the scheme with staff participating in the development of the scheme. Training is co-ordinated for care homes staff in the scheme by a local social enterprise, the Tyne and Wear Care Alliance. The Alliance is maximising training opportunities for care homes staff in the locality in order to improve quality within the care homes. The main expected outcomes are: • Reduction in emergency admissions and readmissions • An increase in the number of people supported to die in their preferred place of care • An improvement in the experience of people with out of hospital care
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Project Group includes: Sunderland City Council, Sunderland CCG, South Tyneside Foundation Trust, Sunderland City Hospitals Foundation Trust, Northumberland, Tyne and Wear MH

Foundation Trust, Primary Care/GPs and representatives from Care Homes/Extra Care Services.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The improvement of health services for residents of Care Homes and Extra Care Schemes in Sunderland was identified as a key work programme in 13-14. An enquiry into the quality of healthcare in care homes for older people by the British Geriatric Society (2011) recommended a

- *Structured proactive approach to care, co-ordinated teams working together, built on primary care, supported by a range of specialists*
- *Residents and relatives at the centre of decisions about care*
- *Partnership approach with care home providers and social care professionals, shared information/assessments/policies/ training and governance.*

http://www.bgs.org.uk/index.php/bgscampaigns-715/carehomes

Building upon these recommendations, the agreed an approach is to implement the scheme in one locality (Coalfields) in Sunderland, and using the learning, move on to develop and improve services throughout the city.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

By April 2016

- Improved healthcare received by care home and Extra Care residents (BGS – Quest for Quality implemented)
- Elimination of confusion – right person, right time, right place
- Improved quality of care and patient experience (Torbay satisfaction 48% – 100%)
- Improved response times (e.g. Physio 8 weeks to 48 hours Torbay)
- Lower hospital death rates (Torbay 44.6%, national 58%)
- Reduced emergency admissions to hospital
- Reduced re-admission to hospital
- Improved quality of care in care homes (Gold standard Homes across the city)

By April 2018

- Improved quality of healthcare for all care home and extra care residents

By April 2021

- Improved quality of healthcare for all care home and extra care residents

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Via integrated transformation board
What are the key success factors for implementation of this scheme?
The key success factor will be that by 2015 the delivery of enhanced healthcare to residents in care homes and extra care schemes across the city, is integral to Community Locality Integrated Working. Ensuring that these programmes are joined up and compliment one other from a delivery perspective will be developed during 2014-15. The main actions during 2014-15 to ensure success are: • Continue delivery within the Coalfields area of Sunderland and consider expansion of the service to other areas and populations • Evaluating the scheme and understanding best practice, and patient feedback, to inform model development. • Developing standard processes and quality measures for delivery of enhanced care by multi disciplinary teams • Review training needs of the workforce, including clinicians and care homes staff • Agree data sharing agreements for the safe management of patient records • Communications plan with stakeholders

Scheme ref no.
BCF 4
Scheme name
Packages of Care – Home Based
What is the strategic objective of this scheme?
The local offer to support people to continue living in their own homes and communities
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme relates to both traditional care and support delivery within people's own homes; alongside developing a range of low level support options to enable people to access the universal preventative and information, advice and guidance offers that are available across the city. Key outcomes are: - Self management of needs - Better management of long term support in the community - Reduction in admissions to care homes - Reduction in avoidable admissions to hospital - Improved discharges from hospital Assumptions: Statutory Guidance of the Care Act will be implemented – national eligibility criteria will be in place Sufficient supply of the right care and support services will be available
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Sunderland City Council, Sunderland CCG, South Tyneside Foundation Trust, Sunderland City Hospitals Foundation Trust, Northumberland, Tyne and Wear MH Foundation Trust, Primary Care/GPs, representatives from VCS, representatives from Independent Sector and Sunderland Care and Support (Local Authority Trading Company).

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence Base:

Shorter term input with good IAG offer reduces demand for longer term involvement

Support at home enables people to remain in their own homes; without need for institutional care

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

16 – Delivered Care Act requirements

2017 – Remodelled pathways for accessing early support, preventative and IAG Offers

2019 – Integrated health and social care packages supporting people with complex needs in their own homes through full integrated locality working

2021 – Right care in the right place at the right time

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Vision for Integration has been developed taking into account the JSNA and JHWS; with the CCG and LA strategic plans being used as the basis of the development of the vision.

What are the key success factors for implementation of this scheme?

Key success factors:

Implementing see and solve approach – short term input with quick resolutions to meet needs

Further development of self-assessment options for accessing equipment and adaptations

More people are supported appropriately within their own homes – across a range of health and social care needs, including EoLc and Palliative Care.

Scheme ref no.
BCF 5
Scheme name
Supporting Carers
What is the strategic objective of this scheme?
Supporting carers to continue in their caring roles and to maximise their health and wellbeing
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The scheme covers a range of interventions to support carers in their caring roles, to enable the identification of carers within Primary Care and to maximise their health and wellbeing through the following key outcomes: - Information and advice - Active and supportive communities - Flexible and integrated support - Supportive workforce - Enabling people to take risks - Having control over care and support provided Assumptions: - Care Act Statutory Guidance is implemented – carers assessments, eligibility for services to support carers - Investment in key areas of priority, in line with Sunderland Multi-agency Carers Strategy
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Project Group includes: Sunderland City Council, Sunderland Clinical Commissioning Group, City Hospitals Sunderland Foundation Trust, Sunderland Carers Centre, Sunderland College, University of Sunderland and other representatives from VCS.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evidence Base: - National Carers Strategy - Making it Real for Carers Programme – (TLAP) - Local Mutli-agency Carers Strategy

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

2016 – Delivered Care Act requirements; Essence Service is impacting positively on people with dementia and their carers

2017 – Remodelled pathways for recognising carers within Primary Care, who can then access the early support, preventative and IAG Offers – reducing admissions to care as a result of family breakdown

2019 – Building on the role that carers play supporting the health and social care system as a key partner in achieving the ambition for integration

2021 – Right care in the right place at the right time – for both individual and their carer/s.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

At present, the needs of carers are reflected across the range of JSNA profiles in place – in order to fully align the work and ambition of the Supporting Carers Scheme, it is proposed that a JSNA is undertaken which focuses on carers – this will support the implementation of the Supporting Carers Scheme in Sunderland.

What are the key success factors for implementation of this scheme?

Key Success Factors:

Carers are appropriately supported to maintain their caring role, reducing the number of crisis family breakdowns which result in the need for admissions to care homes or acute health care services

Recognition of carers takes place at an earlier stage; in order that information, advice and guidance is available to support carers

Access to appropriate short breaks and opportunities supports on-going care to be provided through the carer having a ‘break’.

Carers of people with dementia are supported through the development of the Essence Service – collaboration within the VCS to provide appropriate, timely and flexible responses to carers and people with dementia.

Scheme ref no.
BCF 6
Scheme name
Learning Disabilities
What is the strategic objective of this scheme?
Care Pathway for people with learning disabilities
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Review of the health and social care pathway for people with learning disabilities, including acute hospital, community health, primary care and social care interventions Key Outcomes: - Expectations from Winterbourne Review are met - Single pooled budget across health ansd social care in respect of LD - Ensure spend is appropriate and proportionate across the markets - People with learning disabilities receive the right support based on their health and social care needs. Assumptions: - Recommendations from Winterbourne Review are fully implemented - The Care Act is implemented - The Markets which provide care and support to people with learning disabilities are appropriately managed
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Project Group includes: Sunderland City Council, Sunderland CCG, Sunderland City Hospitals Foundation Trust, Northumberland, Tyne and Wear MH Foundation Trust, User Led Organisation and representatives from VCS.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Evidence Base: - Care Act - Winterbourne View Review

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
2016 – Delivered Care Act requirements and Winterbourne View Review recommendations 2017 – Spend is proportionate and costs are in line with comparative neighbours across all markets 2019 – Integrated health and social care packages supporting people with complex needs in their own homes through full integrated locality working 2021 – Right care in the right place at the right time
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The Vision for Integration has been developed taking into account the JSNA and JHWS; with the CCG and LA strategic plans being used as the basis of the development of the vision
What are the key success factors for implementation of this scheme?
Key Success Factors: - Care Act and Winterbourne Review recommendations are implemented - People are maximising their life opportunities - Costs associated with provisions are in line with comparative neighbours - People are appropriately supported in the right environments

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Sunderland
Name of Provider organisation	City Hospitals Sunderland NHS FT
Name of Provider CEO	Ken Bremner
Signature (electronic or typed)	 Dep. CEO CHSunderland

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	31,010
	2014/15 Plan	30,916
	2015/16 Plan	30,676
	14/15 Change compared to 13/14 outturn	-0.3%
	15/16 Change compared to planned 14/15 outturn	-0.8%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	94
	How many non-elective admissions is the BCF planned to prevent in 15-16?	240

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes for 14/15 and 15/16, however, we disagree with the impact for years 16/17 – 18/19
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	For future years (16/17 – 18/19) we have planned on the CCG achieving 50% of their target. Our assessment includes: • future projections of increasing demand (48% increase over 10 years for the 85+ population), • historical delivery of plans by commissioners,

		• other local commissioners believe stopping current growth is realistic (flat line), but reducing demand further is not, and • the increased complexity (multiple co-morbidities) of an ageing population.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes, for future years we have planned on the CCG achieving 50% of their target. The impact in terms of income, workforce and physical capacity have been planned for and referenced in the Trust's 5 year strategic plan. If the full target is achieved, the Trust understands the implications of this and the associated risks.