County Durham

Better Care Fund Plan

2017 – 19

CONTENTS **Page No.**

I. Introduction

The Better Care Fund Plan 2017/19 for County Durham remains consistent with the key priorities and outcomes of the Health and Wellbeing Board and is focussed on the progressive integration of health and social care services.

The 2017/19 plan responds to national priorities identified in the NHS Five Year Forward View and builds upon a long and well established history of joint and collaborative working in County Durham across the health and social care community.

We recognise the need to transform our health and social care system to meet the challenge of better health, better care and financial sustainability going forward, and there is a shared and demonstrable commitment in County Durham to deliver on this agenda.

2. Plan Details

Local Authority	**Durham County Council**	
Clinical Commissioning Groups	**North Durham (ND) CCG**	
	Durham Dales, Easington and Sedgefield (DDES) CCG	
Boundary Differences	Given the close proximity of County Durham and Darlington there are several projects which are carried out jointly with Darlington CCG and Darlington Borough Council supported by North of England Commissioning Support. There are some similarities in the plans for neighbouring CCG's and Local Authorities particularly in relation to integration; Intermediate Care, frailty, discharge management and out of hospital services. The impact upon providers is discussed in a number of fora including County Durham Health and Wellbeing Board.	
Date agreed at Health and Well-Being Board:	Delegated authority to sign off the BCF Plan to the Corporate Director, Adult and Health Services, Durham County Council, the Chief Clinical Officer in DDES CCG and the Chief Operating Officer, ND and DDES CCG's in consultation with the Chair of the Health and Wellbeing Board.	
Minimum required value of BCF pooled budget 2017/18	**£45,698,016**	**Total including iBCF £61,188,287**
Minimum required value of BCF pooled budget 2018/19	**£46,874,077**	**Total including iBCF £68,349,536**
Impact of the changes on services	The County Durham BCF Plan for 2017/19 is based upon rolling forward existing schemes and projects with opportunities afforded through the iBCF to support and maintain social care and system related pressures following agreement between partners.	

3. Authorisation and Sign Off

Signed on behalf of the Health and Wellbeing Board	
By: the Chair of the Health & Wellbeing Board	Councillor Lucy Hovvels
Date:	
Signed on behalf of Clinical Commissioning Groups	
By: Chief Operations Officer, North Durham & Durham Dales, Easington & Sedgefield CCGs	Nicola Bailey
Date:	
Signed on behalf of Durham County Council	
By: Corporate Director Adults & Health Services	Jane Robinson
Date:	
Signed on behalf of Clinical Commissioning Groups	
By: Chief Clinical Officer, Durham Dales, Easington & Sedgefield CCG	Stewart Findlay
Date:	

4. Related Documentation

Document or information title
Integrated needs Assessment (INA)
Joint HWB Strategy 2016/19
North Durham CCG Operational Plan 2017/19
Durham Dales, Easington & Sedgefield Operational Plan 2017/19
Accountable Care Network (Memorandum of Agreement)
Project Initiation Document – Adult Integration and Teams Around Patients (TAPs)
System Risk Register
Health and Wellbeing Board Governance Structure
High Impact Change Model – Managing Transfers of Care (Action Plan)

5. The local vision for health and social care services

Our vision for Integrated Care

To bring together health, social care and voluntary organisations to achieve improved health and wellbeing for the people of County Durham

5.1. The principles which underpin our integration vision are:

5.1.1. Uniting stakeholders behind the vision for integration
5.1.2. Developing a shared understanding of integration between partners
5.1.3. Joining up delivery where it made sense for the service user which is efficient, cost effective and outcome focussed
5.1.4. An emphasis on community based solutions
5.1.5. A whole system approach to early intervention and prevention which promotes independence and wellbeing

Minimum KLOE	
Criteria	**Rag Rating**
• The area's vision for 2020	
• BCF Plan Alignment with wider system transformation	
• Diagram of Vision	
• Agreed outcomes	
• Does the plan complement the NHS Five Year Forward View	

5.2. By 2020 we will have worked together to achieve the following outcomes:

- Transformed service delivery through integrated working
- Further improved hospital discharge planning
- Reduced unplanned and avoidable admissions to hospital
- Maintained more people at home
- Reduced inappropriate admissions to residential or nursing care homes
- Improved joint 24/7 working to be more responsive in meeting people's needs
- Improved access to technology to support and maintain people in their own homes
- Developed stronger communities to reduce social isolation
- Reduced health inequalities
- Increased choice and control through personal budgets
- Supported more carers in their caring role.

5.3. The joint BCF Plan is recognised as one of the influential drivers in the delivery of the NHS Five Year Forward View and is considered important by all stakeholders in the delivery of transformational change through the integration of health and social care to improve the health and wellbeing of the population.

5.4. The two local Sustainability and Transformation Draft Plans: Northumberland, Tyne & Wear and North Durham (NTWND- STP) and Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (DDTHRW-STP) bring together organisations to develop shared plans for better health and care to local populations based upon need with initiatives to develop services by place rather than individual institutions. STP's are expected to support closing three gaps across health and social care systems highlighted in the NHS Five Year Forward View:

- Health and Wellbeing
- Care and Quality
- Funding and financial efficiency.

5.5. The STP's are a mechanism for delivering the NHS Five Year Forward View in developing genuine and sustainable transformation in health and social care outcomes. To date we have an overreliance on hospital based care than other parts of the Country and our intention is to strengthen care delivery outside of hospital and involve neighbourhoods, communities and individuals who will be able to take greater control of their health and maintain independence for longer, whilst preventing or delaying the need for increased services.

5.6. The NHS Five Year Forward View provided the national policy context and presented two leading care models: Primary and Acute Care Systems (PACS) and Multi-speciality Community Providers (MSP's). Following engagement with stakeholders through the Better Health Programme and draft Sustainability and Transformation Plans (STPs) both North Durham and Durham Dales, Easington and Sedgefield CCGs sought to re-shape out of hospital care around the fundamentals of the MCP model.

5.7. MCPs build upon the strengths of 'expert generalists' proactively targeting services towards patients with complex needs including frail elderly and those with chronic long term conditions, and working more intensely with this group of patients. The model expands the leadership of primary care to include community nursing, therapies and other community based professionals.

5.8. The CCGs plan to commission MCPs alongside the health and Wellbeing Board which authorised additional scoping work on integration led to the development of Teams around Patients (TAPs) and the re-shaping of care and support services around them.

5.9. The TAPs model acknowledged that more care should be delivered to community settings through integrated provision. The frontline workforce making up the TAPs would focus on patients with complex needs but also minded to prevention and the promoting of independence. These teams would work across a group of GP practices and it is also envisaged that the voluntary sector will be involved in providing solutions to meet needs.

5.10. Across County Durham the proposal for 13 TAPs was agreed around populations of between 30,000 – 50,000 with the principle outcomes being:

- Improved primary care access
- Strengthening the preventative offer
- Improving health and wellbeing through risk stratification
- Reducing presentation at Accident and Emergency
- Reducing unnecessary bed days in hospital
- Avoiding inappropriate admissions of people into residential and nursing care homes

5.11. TAPs and wider integration of health and social care are managed through an Accountable Care Network (ACN) which provides a line of accountability and governance, with commitment from all partner organisations. The ACN alliance approach formally brings together all partners, working towards the same aims, but does not give one organisation leadership over the others and enables each to retain its own services. The project plan contained in the Project Initiation Document identifies the establishment of the Accountable Care Network.

5.12. To achieve our vision we acknowledge that not only does this require new approaches and the redesign of systems and processes, but also a significant change in culture and behaviour in order to implement and embed change, critical factors include:

- The need to promote and support collaborative working by ensuring that all partners endorse a common vision of co-ordinating care that enables people to experience integrated care, assigned to meet their needs in the most appropriate setting.
- Bringing together existing services in primary care, acute and social care, community services and the voluntary sector into one overall approach.

- Supporting and developing diverse relationships across organisational boundaries through improved networking and local partnerships in order to create the environment for inclusive collaboration and joint working.
- A recognition that integration is an interactive process and will involve 'trial and error' and incremental change as well as sustained effort and commitment to build engagement, momentum and to deliver change.

6. Background and Context to the Plan

6.1. Key stakeholders including CCG's, the Local Authority and care providers have been involved in the discussion and production of the BCF Plan. The BCF Plan is aligned with Health and Wellbeing Board strategic priorities and CCG's operational plans and priorities.

6.2. Key Measures from the Joint Strategic Needs Assessment

- The overall population of County Durham is expected to grow by 4.2% (+21,600 people) by 2024 to 539,500 people. This projected growth is higher than the growth expected in the North East (2.5%).
- By 2024 the number of people aged 65 years will increase by 19.3% (+19,600 people) to 121,000 people and by 47.5% (+48,200 people) by 2039 to 149,700 people.
- By 2024 the 85 years and over age group will increase by 36.9% (+4,300 people) to 15,900 people and will more than double in size by 2039 to 28,700 people.
- Life expectancy for males (78.1 years) but slightly reduced for females (81.4 years) - both are behind the England average (79.5 years) for males and (83.2 years) for females.
- There are over 4,900 people in County Durham registered with a GP with a diagnosis of mental illness, with more than 50,000 suffering from anxiety or depression.
- Prevalence of long term conditions such as diabetes, respiratory disease/coronary heart disease and stroke in County Durham are significantly higher than the England average.
- Estimates suggest that over 6,700 people in County Durham aged 65+ years have dementia. Projections indicate that this figure will almost double by 2030.
- Estimates suggest that 22,000 people aged 18-64 years (7.0%) are socially isolated.

6.3. Our aim is to improve the health and wellbeing of people living in County Durham through innovation and service transformation with a view to reducing reliance on long term health and social care services with an emphasis on prevention and promoting independence. Across County Durham there has been a long history of positive partnership working to improve health and care outcomes for people. Multi agency approaches to planning, commissioning and the provision of services remain at the core of sustaining our communities' health and wellbeing.

6.4. The Health and Wellbeing Board are supported by a number of programme delivery groups which oversee and operationalise the Better Care Fund schemes and projects. The groups have representation from CCG's, the local authority and provider organisations. The Integration Board comprised of Chief Officers from Health and Social Care including provider organisations has a working relationships with the Health and Wellbeing Board. The Integration Board has responsibility for Strategic Leadership, supporting innovation, change management and service delivery across the local health and social care economy, to ensure joint

Minimum KLOE	
Criteria	**Rag Rating**
• Local demography and challenges	
• Health and Social Care Market	

accountability between partner organisations.

6.5. Provider services are represented on the Durham Health and Wellbeing Board and are aware of the utilisation of the BCF. Engagement through 14 Area Action Partnership's (AAP's) at a local level across County Durham facilitates local decision making giving local people and organisations the opportunity to influence service provision. Each AAP has health representation from CCG's as well as Public Health aligned to delivery, with a link back to the Health and Wellbeing Board. Commissioners and providers both recognise that synergies and efficiencies can be realised through integration and re-engineering of services to improve responsiveness and outcomes for people. There is also a recognition that there is an over-reliance on the use of hospital based services, particularly in relation to unplanned care. Processes are in place to maintain productive relationships with providers through consultation and events to engage providers on the strengths and weaknesses of local provision in order to shape the future direction.

6.6. The Social Care Market in Durham is considered to be fairly robust. Durham County Council have well established commissioning arrangements covering residential and nursing care homes, domiciliary and day care services and are able to place care packages in a timely manner to meet need and which support health and social care system requirements. Durham is a high performing area in relation to Delayed Transfers of Care and joint commissioning opportunities and approaches continue to be explored as part of the integration agenda. The role of the third sector is also recognised as a key component in the market place and commissioning approaches reflect this.

In common with similar County Authorities, some pressures on service delivery are evident in the rural areas of County Durham for example, nursing availability in the care home sector. However, work continues to focus on supporting service delivery in these areas.

The Health Care Market in Durham has a number of challenges. There are three NHS Foundation Trusts which provide the majority of acute services for County Durham residents. Ensuring that there are robust and joint dup acute, community and primary care services is a priority. Community services are provided by one of the main Foundation Trusts although there are plans to re-procure these services during 2017/18. Market engagement indicates that there is a lot of interest in delivering these services.

There are a number of services which could be described as fragile due to workforce shortages. These include breast screening services, haematology, paediatrics ad obstetrics. GP recruitment particularly in the more deprived areas of County Durham has been problematic. A primary care workforce strategy is in place with a multi-faceted workforce plan to address this issue. There are some difficulties in recruiting to the nursing workforce. Practice nurses have an ageing demographic and plans are in place to attract nursing staff to this role. Local acute trusts run an overseas nursing recruitment programme to address nursing workforce shortages.

There are no outstanding financial issues concerning the CCG's and the main acute providers. Commissioners hold regular executive level meetings to focus on delivering the QIPP/CIP and system wide efficiencies.

6.7. As a Unitary Authority, Durham County Council holds overall responsibility for housing which is managed through the Regeneration and Local Services Directorate who oversee the Disability Facilities Grant (DFG). The DFG plays a major part in helping people with disabilities to live independently and remain at home. Over the last year 2016/17 the grant has been used to provide a wide range of adaptations including shower and stair lift installations and home modifications including extensions. The importance of the link between housing status and admission and discharge from hospital is firmly acknowledged and considered as part of providing advice and assistance.

6.8. The Local Accident and Emergency Delivery Board (LADB) oversee work focussed on the transformation of urgent and emergency care and effective discharge planning, with system links to the development of integrated community services.

6.9. Better Care Fund performance is reported to the Health and Wellbeing Board on a quarterly basis along with updates to the Integration Board.

6.10. A comprehensive system risk register has been produced in partnership with stakeholders and includes risks associated with the impact upon NHS providers and financial risks and mitigation for the NHS and the Local Authority.

7. Progress to Date

7.1. The Better Care Fund 2016/17 pooled budget enabled our transformation and integration plans to progress through the 7 key local work programmes:

- **Intermediate Care Plus (IC+)** which includes intermediate care community services, reablement, falls and therapy services.
- **Equipment and Adaptations for Independence** which includes telecare, disability adaptations and the Home Equipment Loans Service
- **Supporting Independent Living** which includes mental health prevention services, floating support, supported living and community alarms and wardens
- **Supporting Carers** which includes carers breaks, carers emergency support and support for young carers
- **Social Inclusion** which includes local coordination of an asset based approach to increase community capacity and resilience to provide low level services to maintain and support prevention
- **Care Home Support** which includes care home and acute and dementia liaison services
- **Transforming Care** which supports joint working and integration and shift towards greater care in the community and in the home

7.2. The above programme/schemes were linked to wider strategic transformation programmes including:

- County Durham Health and Wellbeing Strategy
- County Durham and Darlington Urgent Care Strategy
- Transforming Care Fast Track Plan for Durham
- County Durham Dual Needs Strategy for Learning Disability/ Mental Health and concurrent problematic substance misuse

Minimum KLOE	
Criteria	**Rag Rating**
• Existing approach to integration and main points of the BCF Plan	
• Review of progress through the BCF	
• Performance on national metrics and successes	

- Better health Programme/Not in Hospital Group
- Dementia Strategy for County Durham
- County Durham Drug Strategy
- Emergency Care Improvement Programme

7.3. All of the above and other strategies were undertaken with a partnership approach across County Durham

7.4. A number of projects have enhanced integrated working including Intermediate Care Plus Services, Equipment Loans Services, Support for Carers, Wellbeing for Life Services and the current work developing integrated Teams Around Patients (TAPs) through Transforming Care, and other initiatives including Discharge to Assess which are all good examples of integrated working

7.5. Positive joint working between partners through the delivery of the BCF programme has progressed the desire to deliver integrated care between partner organisations across County Durham.

7.6. The Intermediate Care Plus service has been an important catalyst in progressing the need to deliver greater integrated care between partner organisations across County Durham. The multi-agency approach to deliver short term intervention in response to community crises and the avoidance of unplanned emergency admissions and facilitating hospital discharge, has demonstrated the ability of partners to work together, co-located in a supportive environment, with shared learning and confidence to impact positively on patient experience and outcomes.

7.7. The system change required to create functionally integrated holistic teams at GP Practice Group level referred to as Teams Around Patients (TAPs) included community nursing, therapy, social care, specialist nursing and allied health professionals. The TAPs are based around practice populations of 30-50,000 to provide joined up accountable personalised care to patients. Systematic risk profiling of the population to identify the top 2% of patients at high or very high risk of accessing services, assists in identifying and prioritising those patients where more targeted intervention can be most effective.

7.8. The development of the TAPs has been an iterative process which is still ongoing, it has brought together a partnership of organisations under a Memorandum of Understanding. However, in order to be sustainable and realise their full potential, community services need to be commissioned, contracted and progressed through a fully functioning Accountable Care Organisation. There is a shared aspiration to have a combined and integrated management board with service delivery overseen by a Chief Officer on behalf of all partners.

7.9. BCF income and expenditure plans and the delivery of health and social care provision has been maintained amid significant financial pressures across the system.

7.10. Performance on the four National BCF metrics highlights 2 notable successes and 2 areas where targets were not met.

7.11. Reducing **non-elective admissions** has remained challenging for County Durham. The target for Q4 2016/17 was 2930/100,000 population with the outturn at 3022. Whilst the BCF delivery plan has made some impact on non-elective admissions for adults, the most significant increase has been in relation to children 0-18 years admitted for viral infections and common colds with an average length of stay of 1 day or less. County Durham and Darlington NHS Foundation Trust are seeking to improve the pathway for paediatrics through a number of joint initiatives with Primary Care.

7.12. In 2016/17, 804 people aged 65 years and over were **permanently admitted to residential or nursing care homes.** This did not achieve the BCF target of 790. However the number of bed days commissioned has remained relatively stable as more, older people are admitted into residential or nursing care later in life. The average age of older people admitted to residential or nursing care in County Durham in 2016/17 was 86.8 years.

7.13. The **effectiveness of reablement** and rehabilitation services which contribute to prevention and the promotion of independent living led to 87.8% of older people aged 65 years and over remaining at home 91 days post discharge from hospital. This service offers people the opportunity, inducement and confidence to re-learn/regain skills they may have lost as a consequence of ill health, disability, impairment or accident and helps people to stay independent in their own homes for as long as possible.

7.14. Positive performance in relation to **Delayed Transfers of Care** was evident across all BCF quarterly targets in 2016/17. BCF initiatives including Intermediate Care Plus and reablement alongside joint working with hospital discharge have been significant in maintaining performance, whilst recognising the complex array of factors which are at play in relation to hospital discharge. County Durham has a low rate of Delayed Transfers of Care both regionally and nationally.

8. Evidence base and local priorities which support the plan for integration

8.1. An Integrated Needs Assessment (INA) has been developed for County Durham, which brings together, for the first time, the evidence base and a wide range of strategic assessments used to inform strategic planning across the council and by thematic partnerships. The INA provides links to data, analysis, external frameworks, strategies and plans relevant to health and wellbeing in County Durham, contained within the INA are a series of web based topical fact sheets which provide current data and information for stakeholders to inform planning and commissioning of services. The Joint Strategic Needs Assessment (JSNA) is located within the health, Social Care and Wellbeing area of the INA.

8.2. There are a number of adult health outcome measures within County Durham which fall significantly below the national average. An increasing number of people with multiple long term conditions including respiratory and cardiovascular disease and diabetes compounded by demographic pressures present demanding challenges to the health and social care system.

8.3. Both North Durham and Durham Dales, Easington and Sedgefield CCG's have adopted the Joint Health and Wellbeing Strategic Vision to 'improve the health and wellbeing of the people of County Durham and reduce health inequalities' which run through the two year operational plans to ensure linkages and consistency.

8.4. The priorities identified in this plan have been developed and agreed jointly by both CCG's, Durham County Council, County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust. By adopting asset based approaches we aspire to build resilience and capacity into our communities in order to reduce and delay their reliance on statutory health and social care services and thereby ensure capacity within services to provide to those in greatest need.

8.5. Our plan is expected to support spend on out of hospital services of £15.89million in 2017/18 and £16.12 million in 2018/19, to improve the experience and quality of care through 'Out of Hospital' collaboration and the optimal use of the Acute Sector by:

- Developing a resilient and robust primary care sector
- Providing integrated models of care and defining a unified care offering for out of hospital services across the system
- Acute service change through speciality review to meet emerging challenges
- Developing an integrated lifespan approach to needs in relation to mental and physical health, social care which wrap around the person alongside community support and promote choice and control
- This incorporates the impact of the BCF plan as well as wider plans of both CCGs and the local authority.

8.6. County Durham and Darlington NHS Foundation Trust (CDDFT) are the main provider of acute and community services in County Durham. It is recognised that we still have an overreliance on the use of hospital based

Minimum KLOE	
Criteria	**Rag Rating**
• Evidence base for the plan	
• Key successors on challenges from 15/16 and 16/17 and how the 17/19 plan builds on these	
• Reference any notable changes from the 16/17 plan	

services, particularly for unplanned care. Although there has been some progress on integrating services between health and social care providing care closer to home, we recognise that greater integration with primary care including communities and the voluntary sector to offer a more holistic focus on people's needs.

8.7. In 2015/16 and 16/17 Durham committed to 7 key work programmes in the BCF Plan. Performance against the projects and schemes from the programmes have been regularly monitored through project leads and reported to the BCF Monitoring Group and Joint Finance Group and Integration Board. Key success included Intermediate Care Services, Supporting Independent Living, Supporting Carers and Transforming Care. The 2017-19 plan continues to build on these themes with an important focus on the transformation of community services. The current uncertainty regarding the re-procurement of the Community Health Services contract presents some challenges in delivering the BCF Plan. The transformation agenda requires new ways of working and in particular integrated services to facilitate seamless and timely care pathways for people who use health and social care services.

8.8. In recognition of the financial challenges across our local health and care system, there is a clear focus on achieving financial stability and sustainable health and care services through transformation and integration.

8.9. The transformation of community services based around GP Practices working in hubs, supported by Teams Around Patients (TAPs) and locality based integrated community teams are key developments on our journey towards further integration. The case for Change is predictated on the increasing number of people with multiple long term conditions present and demographic pressures which requires health and care services to manage demand more effectively, and the need to redistribute resources appropriately at a community level and away from acute services. 2017/19 will see an increased emphasis on place based systems and pro-active care to meet the challenges.

8.10. Recognising the synergies that can be realised through integrated working we will continue to develop and jointly review working arrangements and services to build continuous improvement and a transformational change culture with a focus on prevention and integrated functions where appropriate.

8.11. In approaching the Better Care Fund Plan in this way we are building on the flexibility to absorb and respond to change and meet the challenges for all partner organisations

9. Better Care Fund Plan

9.1. There are seven programmes within the BCF plan which focus on health and social care initiatives to enable integration of community services which are as follows:

- **Intermediate Care Plus** – which provides a range of integrated services to promote recovering from illness, prevent unnecessary admission to hospital or permanent admission to residential or nursing care home, facilitate timely and safe discharge and support from hospital and maximising opportunities for independent living.
- **Transforming Care** – has a clear emphasis on integration. The Accountable Care Network (ACN) has established a framework for collaboration between partner organisations with regards to integrated care across County Durham and includes services such as Intermediate Care Plus and Teams Around Patients (TAPs) alongside workforce development and training and the re-designing of care pathways and improvements in service delivery.
- **Equipment and Adaptations for Independence** – the joint funding of the home equipment loans service following service redesign to improve access to equipment and adaptations and make greater use of advancing technologies.
- **Supporting Independent Living** – includes mental health prevention and recovery services which focus on the wider determinants of health such as accommodation and employment which relate to good mental health and wellbeing. The programme aligns with the Mental Health Taskforce (2016) Five Year Forward View for Mental health in that it prioritises prevention, access, integration and positive experiences of care.
- **Supporting Carers** - in recognising the value and contribution that carers make to the health and social care system and economy we are committed to improve carer support in order to enable them to maintain their caring role and their own health and wellbeing.
- **Social Inclusion** – through an asset based approach we have worked to increase community capacity and resilience working with the Voluntary and Community Sector in order to transform services at a pre-health and social care delivery stage through prevention and access to universal services, facilities and resources which promote wellbeing and help to avoid the development of needs for health and/or social care services.
- **Care Home Support** – we are committed to high quality care home provision which includes dementia liaison services. Our endeavours focus on the competency and capability of homes to provide high quality care which ensures person centred care, dignity and that safeguarding adults standards are met and help avoid unnecessary admissions into hospital.

Minimum KLOE	
Criteria	**Rag Rating**
• Brief description of schemes and priorities	
• Intended impact of schemes	
• How the plan supports integration	
• Approach to the use of the improved Better Care Fund	
• Approach to the Disabled Facilities Grant	

9.2. The agreed approach to the use of the improved Better Care Fund (iBCF) centres around 3 key initiatives:

- **Supporting people with complex learning disability needs in the community** – by improving community infrastructure, supporting the workforce, avoiding crises, early intervention and prevention to support people in the community and avoid the need for unnecessary hospital admission.
- **Supporting people with complex needs associated with dementia in the community** – by improving dementia pathways, reducing risk, promoting dementia friendly action, education, training and supporting the workforce across health and social care.
- **Maintaining social care and system related support –** by maintaining existing capacity within the system where services are retained at the stable level of service user satisfaction.

9.3. Through our partnership working we have understood the important role of housing across the health and social care system. The agreed approach to use of the Disabled Facilities Grant has been through sharing information and improving access to advice both to the public and front line staff in supporting people in their own homes through the use of equipment and adaptations. Occupational therapy staff meeting with housing every month to consider DFG applications which regularly includes feasibility visits to properties to ensure that any adaptations are 'future proofed' to avoid crisis intervention. Every effort is made to utilise DFG resources to best effect which includes prevention and early intervention.

10. Risk

10.1. Durham Dales, Easington and Sedgefield CCG and North Durham CCG together with Durham County Council have agreed that there will not be a formal financial risk sharing agreement relating to the BCF Plan 2017/19. The rationale informing the decision was it was felt more appropriate to focus on transforming service delivery through the full use of the BCF monies rather than use those financial resources to mitigate against risk. Furthermore, operational risk is invariably managed by the organisation which sponsors the scheme or project.

10.2. Each system partner manages the risk for under/over performance for example; if targets for residential or nursing home placements exceed target then the local authority budget would be expected to cover the increased demand from the wider social care budget.

10.3. Both CCG's have historically managed activity variances and employ a number of process and governance structures to identify these at an early stage and mitigate as necessary. The CCG's hold both contingency and specific risk reserves based upon calculated risk at plan stage where financial resources could be utilised should investment be required for any mitigation or corrective action. Financial recovery processes have been developed by both CCGs which can be implemented as required to manage risk during the year, with joint work plans and actions agreed with the main acute provider to jointly manage risk across the health economy.

10.4. A system-wide risk register is in place across the health and social care economy which is reviewed by the Integration Board on a monthly basis.

10.5. In County Durham we recognise that failure to meet BCF targets would have an adverse impact on the quality of life and experiences of people when they need health and social care services. Our plan is focussed on community services and integrated service delivery in order to improve the health and wellbeing of our population.

Minimum KLOE	
Criteria	**Rag Rating**
• Approach to managing risk in the delivery of the plan including risk sharing and contingency arrangements	
• Describe risk owners, mitigations and reporting arrangements	
• The level of risk in the BCF shall not be expected to address system wide risk (including system in the risk register)	

11. National Conditions

11.1. **National Condition 1: Plans to be jointly agreed**

- The BCF plan, covering a minimum of the pooled fund specified in the spending review and Spring Budget 2017 has been 'signed off' by the Health and Wellbeing Board under delegated authority, and by CCGs and Durham County Council.
- In agreeing the plan, both North Durham and Durham Dales, Easington and Sedgefield CCGs and Durham County Council have engaged with provider organisations who are likely to be affected by use of the BCF in order to achieve the best outcomes for people. The implication for providers have been considered and clearly set out for the Health and Wellbeing Board.
- There is local agreement on the use of the Improved Better Care Fund (iBCF) grant to Durham County Council following discussions with both CCGs. The iBCF will be directed towards areas of complex need, in Learning Disability and dementia and to support and maintain social care and system related support.
- As a unitary authority Durham County Council has overall responsibility for housing which is managed through the Regeneration and Economic Development Directorate who oversee the Disabled Facilities Grant (DFG). Housing are represented at interagency forums across health and social care.

11.2. **National Condition 2: Social Care Maintenance**

- The total amount from the BCF which has been allocated to support social care services for 2017/18 is £17.538m and £17.998m in 2018/19 and are included in the BCF Planning Template.
- As this allocation is an increase from the 2016/17 BCF there is no change to report that would adversely impact upon the stability of the health and social care economy.
- There is recognition between partners that spend on social care services does benefit health across a number of schemes and projects including: Intermediate Care, Equipment and Adaptations, Transforming Care, Mental Health Prevention Services, Reablement etc.

11.3. **National Condition 3: NHS Commissioned Out of Hospital Services**

- The NHS Out of Hospital Service spend is reflected in the BCF Planning Template, the amount for 2017/18 is £15,891m and £16,124m in 2018/19. NHS Out of Hospital Services include: community nursing, therapy services, intermediate care, carers support etc.
- No additional target has been set for non-elective admissions. Joint funds are being held in contingency and agreements are in place through the Joint Finance group to release funds from contingency into the BCF.

Minimum KLOE	
Criteria	**Rag Rating**
• Agreement on the BCF plan including organisations affected by the plan	
• Agreement on the use of the iBCF	
• Approach in relation to the DFG	
• Amount allocated from the BCF to support social care and any adverse impact upon the stability of the health and social care economy	
• Spend on social care which benefits health	
• Describe the amount allocated to NHS Out of Hospital Services	
• Describe use of the High Impact Change Model for managing transfers of care	
• Comment on those aspects of the model which are being funded outside of the BCF	
• Timescales for aspects of implementation	

11.4. **National Condition 4: Managing Transfers of Care**

- The High Impact Change Model (HICM) has been utilised and has been discussed as part of Emergency Care Improvement through operational groups and the Local Accident and Emergency Delivery Board. The action plan from the HICM has recently been revised and provides an update on those aspects of the model which are already being implemented and those areas where work is ongoing. (Section 4 Related Documents)
- There are no elements of the HICM which are being funded from outside of the BCF.
- The action plan sets out timelines for implementation on specific elements of the model.

12. National Metrics

12.1. Non-Elective Admissions

- The pre populated figures in the template reflect a 1.3% reduction in 2018/19 which does not mirror CCG's operational plans. However, it is likely that the out-turn for 2016/17 was higher than anticipated which suggests a reduction in 2018/19. CCG's are experiencing difficulty reconciling the figures across County Durham particularly as they appear to be at variance with NHSE metrics.

- The narrative below reflects a net zero change position suggesting no further reduction in activity below the NEA's trajectories. There has been a significant variation over the past three years in relation to non-elective activity. Both CCG's have seen growth and reductions over a three year period (marked decrease in DDES CCG in 2016/17 then growth in 2017/18 and the complete opposite position in ND CCG). The net change over the three year period has been relatively static. There is projected growth in the elderly population and the CCG's expect 2.5% growth in NEA's as a consequence of the anticipated demographic changes. Therefore any attempt to maintain zero growth is in real terms a 2.5% reduction in NEA's.

- Both CCG's have commissioned a number of services jointly with Durham County Council in an attempt to address NEA's including Intermediate Care services. Also a significant amount of work has been carried out in County Durham to develop Teams Around Patients (TAP's). In addition there are now Urgent Care Services in position, extended Primary Care access across County Durham and the Emergency Care Improvement Plans are being implemented. All of these initiatives combined will help to maintain zero growth.

12.2. Admissions to Residential/Nursing Homes

- The ambition is to maintain current levels of permanent admissions. Demographic pressures will see the demand for permanent admissions to residential and nursing care homes continuing to increase. Current evidence in Durham indicates that people are admitted to residential and/or nursing care later in life with particular pressures on specialist dementia and complex nursing needs.

12.3. Effectiveness of Reablement

- Performance of reablement in Durham is good at 87.8% compared to national data. The service contributes to prevention and the promotion of independent living and offers the opportunity for people to re-learn/regain skills which they may have lost following ill health or disability. Our ambition is to improve access to the service whilst maintaining high levels of performance and outcomes.

12.4. Delayed Transfers of Care

- County Durham continues to have one of the lowest rates of delayed transfers of care both regionally and nationally. Our ambition is to maintain these low levels through strong integrated working. It may have been expected that the DToC metrics would be proportionate to the extent of the DToC

Minimum KLOE	
Criteria	**Rag Rating**
• Describe how the NEA metric has been reached and comment on previous performance and likely impact of BCF schemes in 2017/19	
• Comment on whether a further additional reduction in NEAS has been set	
• Comment on the admissions to residential care homes targets, analysis of performance and impact of BCF schemes in 2017/19	
• Describe the metric for reablement, analysis of past performance and likely impact of BCF schemes in 2017/19	
• Provide narrative on DTOC and the metrics in the planning template. • Comment on initiatives that will contribute to maintaining low rates of delayed transfers of care.	

problem in each HWB area but this was clearly not the case. Those areas including Durham HWB with a below average rate of DToC's have resulted in the NHS Better Care Fund National Team trajectory allowing for an increase in DToC rate reductions even though the starting position was significantly below the national average. As a consequence, Durham HWB now finds itself in a very difficult position in being unable to meet with DToC reductions prescribed in the pre-populated template. Despite the invitation to re-submit a revised DToC trajectory which provided a realistic profiling reflecting Durham HWB's historically good performance, regrettably this was not accepted by the Better Care Fund National Team.

13. Programme Governance

13.1. The Health and Wellbeing Board (HWB) in County Durham agree the Better Care Fund (BCF) plan and developments in relation to integrated care. The governance structure contained clearly evidences the HWB joint working arrangements and the approach to managing delivery of the BCF programme. Performance updates on the BCF are reported to the HWB on a quarterly basis against the national metrics for measuring the progress of integration.

Minimum KLOE	
Criteria	**Rag Rating**
• Describe the governance arrangements for the BCF	
• Governance structure diagram	