North Tyneside Council

Health and Wellbeing Board

Friday, 2 June 2023

A meeting of the Health and Wellbeing Board will be held:-

on **Monday, 12 June 2023**

at **10.00 am**

in **Room 0.02, Quadrant, The Silverlink North, Cobalt Business Park, NE27 0BY**

Agenda Item		Pages
1.	**Apologies for Absence** To receive apologies for absence from the meeting.	
2.	**Appointment of Substitute Members** To receive a report on the appointment of Substitute Members. Any Member of the Board who is unable to attend the meeting may appoint a substitute member. The Contact Officer must be notified prior to the commencement of the meeting.	

If you need us to do anything differently (reasonable adjustments) to help you access our services, including providing this information in another language or format, please contact democraticsupport@northtyneside.gov.uk

3. **Declarations of Interest and Dispensations**

Voting Members of the Board are invited to declare any registerable and/or non-registerable interests in matters appearing on the agenda, and the nature of that interest. They are also invited to disclose any dispensation in relation to any registerable and/or non-registerable interests that have been granted in respect of any matters appearing on the agenda.

Non voting members are invited to declare any conflicts of interest in matters appearing on the agenda and the nature of that interest.

Please complete the Declarations of Interests card available at the meeting and return it to the Democratic Services Officer before leaving the meeting.

4. **Minutes** 5 - 10

To confirm the minutes of the meeting held on 23 March 2023.

5. **Better Care Fund Plan 2023/25** 11 - 76

To sign off the Better Care Fund Plan 2023-2025.

Members of the Health and Wellbeing Board:-

Councillor K Clark (Chair)
Councillor P Earley
Councillor J O'Shea (Deputy Chair)
Councillor P Oliver
Councillor J Shaw
C Armstrong, North East Ambulance Service
B Bartoli, Northumbria Healthcare NHS Trust
E Binks
K Blomfield
C Briggs, NHS England
L Buckley, NHS North East & North Cumbria Integrated Care Board
W Burke
J Charlton, Healthwatch North Tyneside
L Cook
J Firth
P Garner, Newcastle Hospitals NHS Foundation Trust
C Gavin, Community & Voluntary Chief Officers Group
P Jones, Healthwatch North Tyneside
C Lilly, North Shields Primary Care Network
C Mann, Cumbria, Northumberland, Tyne & Wear NHS Trust
D McNally, Age UK North Tyneside
P Mennell
G Morris, North of Tyne Local Pharmaceutical Committee
A Paradis, North East and North Cumbria Intergrated Care Board
K Richardson, Wallsend Primary Care Network
R Scott, Whitley Bay Primary Care Network
J Sparkes
B Swan, TyneHealth
S Thomas, Tyne & Wear Fire and Rescue Service
D Titterton, North Tyneside YMCA
C Wheatley, Northumbria Police
Janet Arris
Gary Charlton
Wendy Hume, Chief Officer PA
Jacqueline Laughton, Assistant Chief Executive
Rachel Nicholson, Senior Manager Public Health
Michael Robson, Democratic Services Officer
Scott Woodhouse

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Health and Wellbeing Board

Thursday, 23 March 2023

Present: Councillor K Clark (Chair)
Councillors P Earley and J O'Shea
Wendy Burke, Director of Public Health
Julie Firth, Interim Director of Childrens Services
Eleanor Binks, Interim Director of Adult Services
Jackie Laughton, Assistant Chief Executive
John Sparkes, Director of Regeneration and Economic Development
Peter Mennell, Director of Housing and Property Services
Anya Paradis, North East and North Cumbria Integrated Care Board
Jud*y* Scott, Healthwatch North Tyneside
Paul Jones, Healthwatch North Tyneside
Chloe Mann, Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust
Kathryn Blomfield, North West Primary Care Network
Steven Thomas, Tyne & Wear Fire & Rescue Service
Steve Martin, Dept of Work and Pensions
Dawn McNally, Age UK North Tyneside
Geraint Morris, North of Tyne Pharmaceutical Committee
Cheryl Gavin, Voluntary and Community Sector Chief Officer Group
Dean Titterton, YMCA North Tyneside

In attendance: Rachel Pearse, Claire Dunn, Rachel Nicholson, Chris Woodcock, Louise Gray, Michael Robson, North Tyneside Council
Sam Rennison, Northumbria Police
Ross Wigham, Northumbria Healthcare NHS Foundation Trust

Apologies: Councillors J Kirwin and P Richardson
Julia Charlton, Healthwatch North Tyneside
Patrick Garner, Newcastle Hospitals NHS Foundation Trust
Kirstin Richardson, Wallsend Primary Care Network
Claire Wheatley, Northumbria Police

HW35/22 Appointment of Substitute Members

Pursuant to the Council's constitution the appointment of the following substitute member was reported:-

Judy Scott for Julia Charlton (Healthwatch North Tyneside.

HW36/22 Declarations of Interest and Dispensations

Councillor Karen Clark declared a registerable personal interest in relation to delivery of the Joint Local Health and Wellbeing Strategy "Equally Well: A healthier, fairer future for North Tyneside 2021-25" because she was a Director and Employee of Justice Prince CIC which had contracts with North Tyneside Council to tackle health inequalities and poverty.

HW37/22 Minutes

Resolved that the minutes of the previous meeting held on 9 March 2023 be confirmed and signed by the Chair.

HW38/22 Appointment to the Board

The Board was asked to consider the appointment of a representative from the Department of Work and Pensions as a member of the Board.

The Board had recently agreed a number of appointments to ensure that its membership was appropriate in terms of delivering the ambitions set out in the Joint Local Health & Wellbeing Strategy (JLHWS). The Chair of the Board had suggested that a representative from the Department of Work and Pensions be appointed to reflect its focus on tackling the socio-economic determinants of health inequalities. Steve Martin from the Department had indicated a willingness to serve on the Board and was present at the meeting.

Resolved that a representative from the Department of Work and Pensions be appointed as a member of the Board.

HW39/22 Joint Local Health & Wellbeing Strategy - Fair Employment and Good Work for All

In November 2021 the Board had adopted a revised Joint Local Health & Wellbeing Strategy (JLHWS): Equally Well: A Healthier, Fairer Future for North Tyneside 2021-2025. The Board subsequently agreed a process through which the delivery of the ambitions and actions in relation to each of the seven impact areas contained in the Strategy would be reported and monitored.

In accordance with this process the Council's Director of Regeneration and Economic Development presented a report outlining the progress made in relation to the Fair Employment and Good Work for All theme. It was acknowledged that there was a two-way relationship between work and health: good work was both a result and driver of good health, impacting on the lives of residents and their communities. The evidence was clear that poor health was linked to unemployment and poor-quality work. Closing employment gaps across North Tyneside could unlock prosperity and improve health and wellbeing.

The report described the range of activities being delivered by the Council and its partners. The Board also received a presentation on Working Well North Tyneside which provided a one-stop-shop in North Shields to make it easier for residents to access employment and skills support, plus access to other services and information. The delivery of Working Well was led by the Council but operated in partnership with the NHS, Department of Work and Pensions, and the local community and voluntary sector.

In considering the report the Board:

a) welcomed the strengthened connections between projects designed to secure employment and good work for all and its effect on the health and wellbeing of communities;

b) considered the potential benefits of the proposed new North East devolution deal in terms of increased investment in economic growth, regeneration and skills training;
c) discussed the support that would be required to enable workers aged over 50 to continue in employment, particularly when the healthy life expectancy in North Tyneside was 60.9 years;
d) noted the impact of fair employment and good work on reducing crime and disorder; and
e) acknowledged that work to develop and deliver age friendly strategies ought to be integrated with the Fair Employment and Good Work for All workstream next year.

Resolved that (1) the Board is assured that the respective partnerships are making progress in delivering the actions contained within the Local Health & Wellbeing Strategy (JLHWS): Equally Well: A Healthier, Fairer Future for North Tyneside 2021-2025 and its implementation plan for creating fair employment and good work for all; and
(2) the respective partnerships be requested to submit further progress reports to the Board in relation to their implementation plans for next year, the delivery of those actions and their outcomes.

HW40/22 Joint Local Health & Wellbeing Strategy - Our Lifestyles and Health Behaviours

In November 2021 the Board had adopted a revised Joint Local Health & Wellbeing Strategy (JLHWS): Equally Well: A Healthier, Fairer Future for North Tyneside 2021-2025. The Board subsequently agreed a process through which the delivery of the ambitions and actions in relation to each of the seven impact areas contained in the Strategy would be reported and monitored.

In accordance with this process the Board received a report prepared on behalf of North Tyneside's Drugs Alliance, Healthy Weight Alliance, Strategic Alcohol Partnership and Tobacco Alliance outlining the progress made by them in relation to the Our Lifestyles and Health Behaviours theme contained within the Strategy and implementation plan and some key achievements. It was stated that people making decisions about health and lifestyles was dependent upon and shaped by the context within which they live. There were differences in how people made decisions and the opportunities to change their behaviours. The Strategy therefore sought to support residents by tackling barriers to healthy lifestyle choices and address healthy behaviours in the context of their root causes in the wider determinants of health.

The Board also received a detailed presentation in relation to the Alcohol Health Needs Assessment undertaken in 2022/23 which aimed to understand the impact of alcohol misuse within North Tyneside using a combination of quantitative and qualitative data sources. Based on these findings, the assessment made several recommendations, focusing on strategic leadership; prevention, early intervention, and screening; data and intelligence; structure alcohol treatment; and groups more vulnerable to alcohol harm.

In considering the report the Board:
a) heard about the impact of alcohol misuse on the increasing instances of violent and abusive behaviour by people accessing health services;
b) discussed how the harm caused by alcohol misuse had to be balanced against the economic and social benefits. It was stated that the current licensing framework was not helpful in helping to address the negative impacts of alcohol on health;
c) welcomed recent enforcement action taken by Trading Standards and Northumbria

Police to seize illegal tobacco which had sent a clear message to businesses that such sales would not be tolerated as they posed a risk to health and were likely to be targeted at young people;

d) considered the effectiveness of different methods of engaging with people with complex and multiple needs and how partners might come together to utilise additional funding to improve access to healthcare; and
e) highlighted the need to address the perceived barriers between mental health support and treatment for substance abuse.

Resolved that (1) the progress made by the respective partnerships in delivering the ambitions and actions in relation to the Our Lifestyles and Health Behaviours theme of the Joint Health & Wellbeing Strategy be noted; and
(2) the recommendations contained within the Alcohol Health Needs Assessment be endorsed.

HW41/22 Joint Local Health & Wellbeing Strategy - An Integrated Health and Care System

In November 2021 the Board had adopted a revised Joint Local Health & Wellbeing Strategy (JLHWS): Equally Well: A Healthier, Fairer Future for North Tyneside 2021-2025. The Board subsequently agreed a process through which the delivery of the ambitions and actions in relation to each of the seven impact areas contained in the Strategy would be reported and monitored.

In accordance with this process the Board received a report in relation to the theme contained within the Strategy concerned with an integrated health and care system. The theme was about enabling different parts of the health and care system to work together effectively, in a way that will improve outcomes and address inequalities. The drive to integrate health and social care services was greater than ever, with improved experience for residents and more community-based support being delivered closer to home. The report set out examples of integration including the establishment of the Integrated Care Board place based arrangements for North Tyneside, collaborative work undertaken by the four Primary Care Networks in North Tyneside and the integration of services at the proposed Backworth Ageing Well Village development.

The Board also received a detailed presentation in relation to Northumbria Healthcare NHS Trust's Community Promise. The Promise was an award winning programme and commitment to focus on the full range of ways the Trust could make a difference to improving the community it served. The commitment was based on six key themes which related to the wider factors impacting on inequalities in the community, namely poverty, education, economy, employment, environment and wellbeing and involved a number of area of joint working with partners.

The Council's Director of Housing and Property Services offered support in relation to delivery of the Ageing Well Village, the North Tyneside Care Academy, in terms of providing affordable homes, and Northumbria Healthcare NHS Trusts Armed Forces Forum.

The Board welcomed the report and the approach taken by partners in North Tyneside to integrate services. There was a good track record of collaboration in the area and it was stated that whilst the report provided examples of this, integration extended much wider than the scope of the report.

Resolved that the progress being made in delivering an integrated health and social care approaches and services be noted.

HW42/22 Place Based Partnership Working in North Tyneside

The Board were provided with an overview of the proposed placed based partnership arrangements in North Tyneside in the context of the developing Integrated Care System across the North East and North Cumbria.

It was proposed that a new committee, the North Tyneside Health, Care and Wellbeing Executive be established to strengthen the current arrangements and support the developing Integrated Care Board (ICB) at place. While the Executive would undertake the statutory commissioning responsibilities and executive actions and decisions delegated to it by the ICB Executive Committee, it would also make decisions and take actions in relation to other shared local priorities within the delegated authority of its members.

It would also be accountable and report directly to the Health and Wellbeing Board as the work of this committee would directly contribute to the delivery of the North Tyneside Joint Local Health & Wellbeing Strategy 'Equally Well' and in particular implementing the key priority of the strategy in relation to health and social care integration.

The Board was presented with details of the proposed membership of the Executive, its relationship with other existing partnerships, its approach to communication and engagement, an agreed set of shared goals and draft local priorities.

The proposals had been formulated in consultation with various partners and they represented the beginning of a process to establish and to develop over time the place based arrangements. The Board discussed the membership of the Executive and how the voice of communities could effectively be heard and influence decision making. Members of the Board stated that they had been reassured by the report which had helped to explain the role of the Executive and its relationship with existing structures.

Resolved that (1) the proposed arrangements for place based partnership working in North Tyneside be noted; and
(2) the shared goals and draft local priorities for the place based arrangements be endorsed.

HW43/22 Health Protection Assurance Report 2023

The Board received an overview of the health protection system and outcomes for North Tyneside. The Director of Public Health had responsibility to provide assurance to the Health and Wellbeing Board that the current arrangements for health protection are robust and equipped to meet the needs of the population.

It was reported that North Tyneside had robust systems in place for the management of existing and emerging health protection issues. These systems were shared across a range of organisations and services including health, social care, environmental health, and public protection and led the Director of Public Health, with governance through the North Tyneside Health Protection Board.

An analysis of the data regarding health protection outcomes for screening, immunisation, communicable diseases, and air quality had highlighted that there were areas that may require further consideration and action to support the delivery of Joint Health and Wellbeing Strategy. Consequently the Health Protection Board would continue to address the key priorities related to health protection in North Tyneside including cancer screening inequalities, vaccination inequalities and increased public and local stakeholder interest in infectious disease outbreaks such as mpox and Strep A. The unprecedented impact of the coronavirus pandemic and its mitigation measures continued to have an impact on screening programmes and other infectious diseases.

Resolved that (1) the areas that require improvement such as addressing inequalities across system wide screening and immunisation programmes be agreed; and
(2) the Board is assured that the local health protection arrangements are robust and local stakeholders should continue to collaborate on a range of prevention and control measures.

North Tyneside Health & Wellbeing Board Report Date: 12 June 2023

Title: Approval of the Better Care Fund End of Year Template for 2022/23 and Plan for 2023-25

Report from:	North Tyneside Council	
Report Author:	Sue Graham	Tel:(0191) 643 4036
Relevant Partnership Board:	Better Care Fund Partnership Board	

1. Purpose:

This report seeks approval of the 2022/23 Better Care Fund (BCF) End of Year Template and approval of the Plan for 2023-25 prior to submission to NHS England by the national deadline of 28 June 2023. The BCF Plan requires spending on all funding elements of the Plan to be jointly agreed by the Authority and the Integrated Care Board (ICB) and for the Plan to be approved by the Health and Wellbeing Board.

2. Recommendation(s):

The Board is recommended to

a) approve the attached Better Care Fund End of Year Template for 2022/23
b) approve the attached Better Care Fund Plan for 2023-25, and
b) authorise the Director of Services for Adults in consultation with the Chair of the Health and Wellbeing Board to authorise any further revisions to the submission on behalf of the Board, before the deadline for submission to NHS England on 28 June 2023.

3. Policy Framework

This item relates to section 9 of the Joint Health and Wellbeing Strategy, “Equally Well: A healthier, fairer future for North Tyneside 2021- 2025” which relates to an integrated health and care system.

This section outlines the approach to supporting everyone to live healthier and fulfilling lives and maintaining independence for longer. The drive to integrate health and social care services is greater than ever, with improved experiences for residents and more community-based support being delivered closer to home being our local objective. There is no single definition of integrated care and services can be joined up in different ways, for example between primary and secondary care, physical and mental health care and health and social care. The key aim is to reduce local health inequalities by improving access and unnecessary variations and fragmentation in care.

4. Information:

The Better Care Fund, has been in operation since 2015/16, and is a government initiative to improve the integration of health and care services, with an emphasis on keeping people well outside of hospital and facilitating discharge from hospital.

The BCF creates a pooled fund, managed jointly by the Authority and the North East and North Cumbria Integrated Care Board (the ICB). The value of contributions to the fund in 2023/24 is £35,331,742 which is an increase of 4.9% over the final 2022/23 BCF pooled fund value.

ICBs are required to contribute a defined amount to the fund to support adult social care and in North Tyneside this amount is £13,007,385. Together with the "Improved Better Care Fund" grant, which is paid direct by Government to the Authority, the BCF supports 22% of adult social care revenue expenditure within the Borough. The fund also provides for £7,412,962 for NHS commissioned out of hospital care.

BCF income helps to fund community based social care services, such as reablement, immediate response home care, CareCall, and loan equipment/adaptations. It also contributes towards the Authority's services offered to support carers, the Community Falls First Responder Service, and to independent living support for people with learning disabilities. Within NHS out of hospital care the fund supports bed based intermediate care, community based support, liaison psychiatry and end of life services.

The BCF Policy Framework for 2023-25 covers a two-year period 2023-2025 however not all of the financial allocations for 2024/25 have been confirmed. It is anticipated that a further return will be required confirming the schemes and financial values in the second year.

There are two policy objectives for the BCF for 2023-25 which remain unchanged from 2022/23;

i. Enable people to stay well, safe and independent at home for longer and,
ii. Provide the right care in the right place at the right time.

These objectives also form two of the three national conditions of the fund for 2023-25 with the third condition being the development of a jointly agreed plan between local health and social care commissioners, signed off by the HWB;

Metrics

The Policy Framework mandates metrics to support the national conditions.

1. Effectiveness of reablement
2. Permanent admissions of older people to residential care
3. Unplanned hospitalisations due to chronic ambulatory care sensitive conditions
4. Discharge to usual place of residence

A new metric has been introduced for 2023-25 around emergency admissions for people aged 65 and over.

The End of Year Report and the Plan documents the current performance against these metrics, sets ambitions for future performance, and explains how the services funded through the BCF work alongside other services to impact the metrics.

There is a new planning template included within the requirements for 2023-25 on demand and capacity for intermediate care for 2023/24.

Governance arrangements

The detailed operations of the Better Care Fund in North Tyneside are set out in a Section 75 Agreement between North Tyneside Council and the North East and North Cumbria Integrated Care Board (ICB). That agreement establishes a BCF Partnership Board with representatives from each party. An updated s75 Agreement will be prepared once the BCF Plan has received approval from the national bodies.

The current and proposed BCF Plan are in line with the place-based strategy developed by the Future Care Programme Board, which has representation from North Tyneside Council, the ICB, local NHS Foundation Trusts, the GP federation, primary care networks, Healthwatch, the Council for Voluntary Service, Carers Forum, and Community and Health Care Forum.

The BCF Policy Framework requires that BCF plans are agreed by Health and Wellbeing Boards. As in previous years, the Cabinet and the Governing Body of the ICB are also asked to agree the BCF Plan. Cabinet agreed the 2023-25 Plan at its meeting on 22 May 2023.

End of Year Template

The Template requires each Health and Wellbeing Board to state that arrangements are in place in the area to meet the four national conditions, to provide an assessment of whether the targets will be met for the four national metrics and to outline spend within the fund.

Within North Tyneside the four national conditions for 2022/23 have been met. However, three of the four targets for the national metrics have not been met.

The fund has been fully spent with the exception of the Disabled Facilities Grant where a cumulative value of £1.257m has been carried forward into 2023/24.

Table 1: Performance against national metrics in 2022/23

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,044.0	Not on track to meet target	Outturn is estimated as 1139 which is 9% higher than target of 1044. This result is worse compared to the 2021/22 outturn of 1125. Challenge is the continuing high level of need / high levels of acuity	Progress with 2 hour urgent community response and establishment of virtual ward for frailty during the year should provide strengthened alternatives in 2023/24
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	90.0%	On track to meet target	Forecasted to be an outturn of 91.5% vs target of 90%. Lack of capacity in homecare continues to be a challenge	Reablement service supports discharge to usual place of residence.
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	402	Not on track to meet target	Estimated to be an outturn of 10% higher level of admissions compared to 2021/22. Lack of capacity in homecare continues to be a challenge and level of acuity in clients is often challenging to support at home in a cost effective manner	New short term step down facilities of residential/nursing beds and short term extra care have prevented some long term admissions
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90.0%	Not on track to meet target	Higher than normal level of deaths and admissions to residential care - criteria for referral being revisited to ensure the right cohort is receiving the service. New structure aimed at providing enhanced career development has been bedding in during the year. Loss of some experienced staff due to retirements	Continued high performing service maintaining good outcomes for clients

Better Care Fund Plan 2023-25

Funding

The minimum value of the North Tyneside BCF is set nationally. Table 2 below shows the value in the current year, and changes from previous years.

Table 2

Income Component	2022/23	2023/24	% change this year
Minimum ICB Contribution	19,326,469	20,420,347	5.66%
Improved Better Care Fund	9,578,514	9,578,514	0.00%
Discharge Support Fund	1,761,723	2,206,549	25.2%
Disabled Facilities Grant	1,869,024	1,869,024	0.00%
Disabled Facilities Grant carried forward	1,157,668	1,257,308	8.6%
Grand total	33,693,398	35,331,742	4.9%

The national framework also stipulates minimum contributions to be paid by the ICB to adult social care, and minimum spend on NHS-commissioned out of hospital services.

Table 3

	2022/23	2023/24	% change this year
ICB minimum contribution to adult social care	12,310,605	13,007,385	5.66%
NHS commissioned out-of-hospital spend	5,492,034	5,802,883	5.66%

Metrics

Targets have been set for the five national metrics as outlined in the Plan.

Capacity and Demand Plan

There is a new requirement for 2023/24 to complete a capacity and demand plan for intermediate care (rehabilitation and reablement) and other short term services lasting up to 6 weeks within the local area.

Narrative Plan

A narrative plan is required which outlines the approach to integration in the local area and how the fund is being used to meet the BCF policy objectives.

5. Decision options:

The Board may either:-

a) approve the attached Better Care Fund End of Year Template set out in the report,
b) approve the attached Plan for 2023-25, set out in the report; and

c) authorise the Chair of the Health and Wellbeing Board to authorise any further revisions to the submission on behalf of the Board, before the deadline for submission to NHS England on 28 June 2023.
or

d) request relevant officers, in consultation with the Chair and Deputy of the Board, to undertake further work to make changes to the submission taking into account the comments and suggestions made by the Board at the meeting.

6. Reasons for recommended option:

The Board are recommended to agree options a, b and c). The continuation of the Better Care Fund presents a major opportunity to take forward the principles of the Joint Health and Wellbeing Strategy. Delay in agreeing a plan for use of the Fund may lead to delay in the release of funds by NHS England.

7. Appendices:

Appendix 1 – The North Tyneside Better Care Fund Year End Template 2022/23
Appendix 2 – The North Tyneside Better Care Fund Narrative Plan 2023-25
Appendix 2 – The North Tyneside Better Care Fund Planning Template 2023-25

8. Contact officers:

Sue Graham, Health and Social Care Integration Manager, North Tyneside Council (tel:0191 643 4036)
Anya Paradis, Director of Place (North Tyneside), NHS North East and North Cumbria ICB, (tel: 0191 293 1157)

9. Background information:

The following background documents have been used in the compilation of this report and are available from the author:-

1. 2023-2025 Better Care Fund Policy Framework. Department of Health and Social Care and the Department for Levelling Up, Housing & Communities.
   2023 to 2025 Better Care Fund policy framework - GOV.UK (www.gov.uk)

2. Better Care Fund Planning Requirements for 2023 to 2025. Department of Health and Social Care and the Department for Levelling Up, Housing & Communities.
   NHS England » Better Care Fund planning requirements 2023-25

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

10 Finance and other resources

The financial implications for the Council and the Clinical Commissioning Group will be considered separately by each organisation as part of their approval processes.

11 Legal

The NHS Act 2006, as amended, gives NHS England the powers to attach conditions to the payment of the Better Care Fund Plan. In 2016/17 NHS England have set a requirement that Health and Wellbeing Boards jointly agree plans on how the money will be spent and plans must be signed off by the relevant local authority and Integrated Care Board.

The Board has a duty under Section 195 of the Health & Social Care Act 2012 to encourage partners to work closely together and in an integrated manner for the purpose of advancing the health and wellbeing of the people in the area.

12 Consultation/community engagement

The Better Care Fund plan has been developed jointly by the Authority and the ICB and consultation on the contents of the Better Care Fund Plan has taken place with local NHS Foundation Trusts and no issues have been raised.

13 Human rights

There are no human rights implications directly arising from this report.

14 Equalities and diversity

There are no equalities and diversity implications directly arising from this report.

15 Risk management

Risk management processes will be outlined within the s75 agreement and managed through the governance arrangements.

16 Crime and disorder

There are no crime and disorder implications directly arising from this report.

SIGN OFF

Chair/Deputy Chair of the Board	x
Director of Public Health	x
Interim Director of Adult Services	x
Interim Director of Childrens Services	x
Director of Healthwatch North Tyneside	x
Integrated Care Board Director of Place	x

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Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.

Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.

If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:
- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist: Complete:
Health and Wellbeing Board:	North Tyneside		Yes
Completed by:	Sue Graham		Yes
E-mail:	sue.graham@northtyneside.gov.uk		Yes
Contact number:	7753113741		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Thu 22/06/2023	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: North Tyneside

Confirmation of Nation Conditions			
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	**Checklist** Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: North Tyneside

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,044.0	Not on track to meet target	Outturn is estimated as 1139 which is 9% higher than target of 1044. This result is worse compared to the 2021/22 outturn of 1125. Challenge is the continuing high level of need / high levels of acuity	Progress with 2 hour urgent community response and establishment of virtual ward for frailty during the year should provide strengthened alternatives in 2023/24	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	90.0%	On track to meet target	Forecasted to be an outturn of 91.5% vs target of 90%. Lack of capacity in homecare continues to be a challenge	Reablement service supports discharge to usual place of residence.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	402	Not on track to meet target	Estimated to be an outturn of 10% higher level of admissions compared to 2021/22. Lack of capacity in homecare continues to be a challenge and level of acuity in clients is often challenging to support at home in a	New short term step down facilities of residential/nursing beds and short term extra care have prevented some long term admissions	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90.0%	Not on track to meet target	Higher than normal level of deaths and admissions to residential care - criteria for referral being revisited to ensure the right cohort is receiving the service. New structure aimed at providing enhanced career	Capacity of the service has been maintained and restructure is bedding in	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: North Tyneside

Income

	2022-23	
Disabled Facilities Grant	£1,869,024	
Improved Better Care Fund	£9,578,514	
NHS Minimum Fund	£19,326,469	
Minimum Sub Total		£30,774,007

	Planned		Actual			
NHS Additional Funding	£0		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£1,157,668		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£1,157,668				£1,157,668

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£31,931,675	£31,931,675

ASC Discharge Fund

	Planned		Actual			
LA Plan Spend	£859,231		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£902,492		Do you wish to change your additional actual ICB funding?	No		
ASC Discharge Fund Total		£1,761,723				£1,761,723

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£33,693,398	£33,693,398

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	

Expenditure

	2022-23
Plan	£31,931,675

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes

Do you wish to change your actual BCF expenditure?	Yes		Yes
Actual	£30,674,367		Yes
	ASC Discharge Fund		
Plan	£1,761,723		
Do you wish to change your actual BCF expenditure?	No		Yes
Actual	£1,761,723		Yes
Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	Underspend on Disabled Facilities Grant due to a range of factors including difficulties with contractor capacity		Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: North Tyneside

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Relationships between leaders continue to strengthen. Local changes due to the restructured NHS organisations and a change in Director of Social Care during the year have served to encourage even closer working. Agile response to establishing additional step down capacity to support discharges early in the autumn is evidence of close cooperation and timely	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	All funding spent in line with plans with the exception of an underspend against the Disabled Facilities Grant.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	Discharges continue to be managed effectively through our single point of access with Health and social care co-located on the hospital site. Health and social care continue to work together to strengthen preventative approaches and ensure the right care is delivered at the right place at the right time.	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	2. Strong, system-wide governance and systems leadership	Relationships between leaders continue to strengthen. Local changes due to the restructured NHS organisations and a change in Director of Social Care during the year have served to encourage even closer working. Agile response to establishing additional step down capacity to support discharges early in the autumn is evidence of close cooperation and timely decision-making	Yes
Success 2	8. Pooled or aligned resources	Discharges continue to be managed effectively through our single point of access with Health and social care co-located on the hospital site. Health and social care continue to work together to strengthen preventative approaches and ensure the right care is delivered at the right place at the right time.	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	6. Good quality and sustainable provider market that can meet demand	Although provider quality in North Tyneside is higher than national average per CQC ratings, workforce recruitment and retention issues continue to cause capacity shortages especially within homecare leading to over use of residential care	Yes
Challenge 2	3. Integrated electronic records and sharing across the system with service users	Lack of system integration continues to cause issues with sharing information across the system. The implementation of systmone will support in some areas	Yes

Footnotes:

Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: North Tyneside

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.

The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.
1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
Additional Transport - secondary care	Other		£54,520	£54,520	0	N/A	No		Yes	Note we have activity information from this scheme in terms of numbers of clients transported but the transport was to support the package or placement put in place so counting these would	no
Additional transport Carepoint	Other		£10,000	£10,000	0	N/A	No		Yes	Note we have activity information from this scheme in terms of numbers of clients transported but the transport was to support the package or placement put in place so counting these would	no
Administration - LA	Administration	<Please Select>	£8,590	£8,590	0	N/A	No		Yes	Reporting introduced new burdens - reporting requirements met	no
Administration ICB	Administration		£9,024	£9,024	0	N/A	No		Yes	Reporting introduced new burdens - reporting requirements met	no
Assistive Technology	Assistive Technologies and Equipment	Community based equipment	£50,000	£50,000	150	Number of beneficiaries	No		Yes	Assistive technology offered to all discharges home dealt with by social care. Technology supports individuals to live at home safely and in some cases lifestyle monitoring helped to identify a	no
Bolster capacity for residential care	Residential Placements	Care home	£197,948	£0	0	Number of beds	Yes	Further evaluation indicated that sufficient residential and nursing step down capacity was in place so proposed investment moved to other areas	Yes	scheme not progressed - funding diverted elsewhere	no
Bolster capacity in homecare/extra care	Home Care or Domiciliary Care	Domiciliary care workforce development	£200,000	£306,585	0	Hours of care	Yes	Engagement with homecare providers and ongoing monitoring of demand and capacity for homecare within the Borough indicated a need for additional support for the homecare sector	Yes	Still early to fully evaluate the success of this funding as we are still collecting data on how providers deployed recruitment and retention payments and what impact these have had. Further	no
Edith Moffatt Reablement flats	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£146,000	£140,000	3,120	Hours of care	Yes	Actual costs slightly lower than planned as plan based on estimated care hours	Yes	Excellent outcomes achieved with the vast majority of clients return home after a temporary stay in extra care. Note costs include rent of the flats in addition to care hours provided. 8	yes
Extend contract for 5 additional intermediate care beds	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£30,000	£57,000	5	Number of beds	Yes	Additional 5 beds made available for more weeks than orginally planned.	Yes	Scheme provided some additional capacity allowing more discharges to be placed in step down beds and allowing those placed to stay longer to continue their rehabiliation with a view	no
Flexible homecare response	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£102,000	£128,035	3,656	Hours of care	Yes	Were able to generate additional hours from within existing Reablement staff team which were not originally in the plan.	Yes	Additional inhouse homecare recruited to enhance capacity - linked to additional vehicle providing more responsive service. Costs include hire of a vehicle	no
Howdon Step Down beds	Residential Placements	Nursing home	£235,000	£252,500	10	Number of beds	Yes	Unit costs were slightly higher than planned and an additional amount for GP cover was included.	Yes	Additional step down beds allowed rapid discharges. Flow maintained through these beds ensuring blockage was not simply transferred downstream from hospital. Outcomes for	yes
Reablement Flats at Havelock Place	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£74,000	£83,328	1,350	Hours of care	Yes	Includes cost of GP cover not in original plan.	Yes	Excellent outcomes achieved with the vast majority of clients return home after a temporary stay in extra care - 6 rooms for 15 weeks	yes
Step down bed - Howdon Care Centre	Bed Based Intermediate Care Services	Step down (discharge to assess pathway 2)	£235,000	£252,500	10	Number of beds	Yes	Unit costs were slightly higher than planned and an additional amount for GP cover was included.	Yes	Additional step down beds allowed rapid discharges. Flow maintained through these beds ensuring blockage was not simply transferred downstream from hospital. Outcomes for	yes
Support for short term residential placements	Residential Placements	Care home	£399,641	£399,641	44	Number of beds	No		Yes	Funding allowed additional short term residential care to be commissioned supporting faster discharges from hospital - 44 beds for 13 weeks	yes
Welfare Assistance for discharges	Other		£10,000	£10,000	134	N/A	No		Yes	Funding supported the provision of additional items like bedding and nightware, heating appliances, energy top ups and deep cleans to remove barriers to discharges. Also funded the	no

North Tyneside Health and Wellbeing Board

Better Care Fund Plan 2023-25

Executive Summary

The Better Care Fund (BCF) plan has evolved over a number of years as an element of the implementation of the North Tyneside Future Care strategy, shaped by the Future Care Programme Board which is our place-based planning mechanism. The Future Care Programme Board includes representatives of the local NHS providers (acute, mental health and primary care), social care, primary care networks, the Council for Voluntary Service, North Tyneside Carers Centre, and the Community and Health Care Forum.

The plan is centred around delivering against the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

To deliver against these objectives the Plan provides for a range of investments in:

- Community-based services, which includes CarePoint - our multi-agency, multi-disciplinary integrated team which delivers a home-first approach to hospital discharge and admission avoidance; reablement; immediate response and overnight home care; adaptations and loan equipment service; telecare including falls first responder service; and seven day social work.
- Intermediate Care beds, including bed-based facilities complemented by a community rehabilitation team
- Out of hospital community health services
- A hospice-at-home service for end of life care
- Liaison Psychiatry for working-age adults
- Support for people with learning disabilities to live independently at home
- Implementation of the Care Act, support for carers, and the provision of advice and information.

The Improved Better Care Fund element will be used to support the social care market to ensure the right care is available, including meeting the costs of paying at least the Living Wage to staff in care homes and home care with movement towards paying the Real Living Wage. These investments also support hospital capacity by helping to ensure that discharge services are sufficient to meet demand.

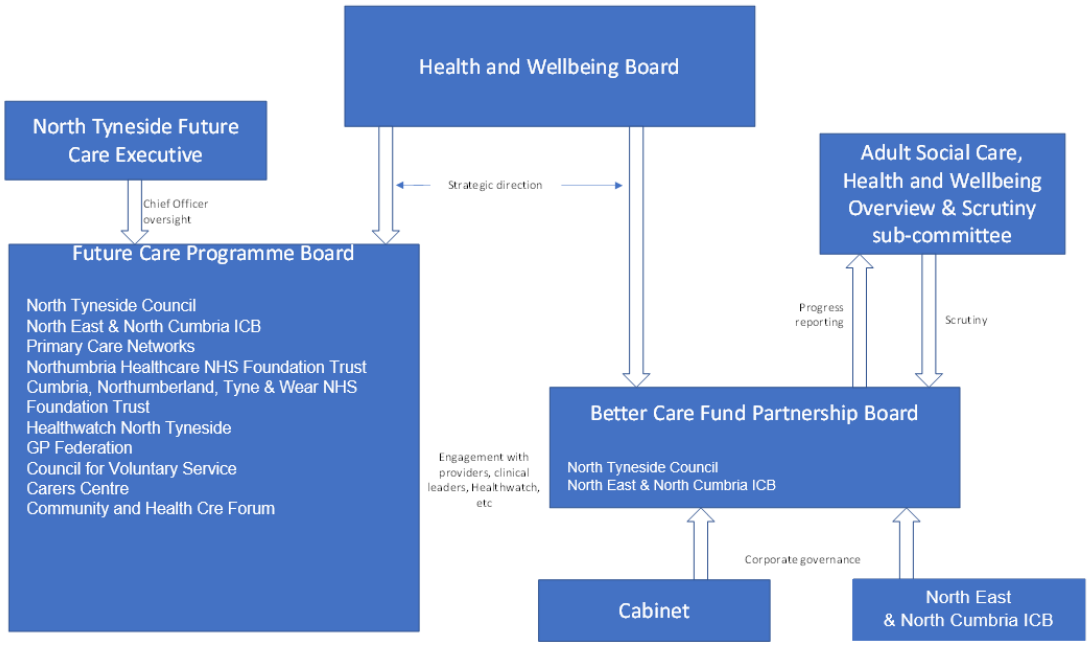
The Disabled Facilities Grant (DFG) will be used to enable people to live independently in their own home; minimise risk of injury for customer and carer; prevent admission to hospital and long term care; reduce dependency upon high level care packages; improving quality of life and wellbeing; maintain family stability; improve social inclusion; and enhance employment opportunities of the disabled person.

The Discharge Support Fund was added to the Better Care Fund for the winter of 2022/23 and continues into 2023-25. This part of the fund aims to enable local areas to build additional adult social care and community-based reablement capacity to reduce delayed discharges and improve outcomes for clients. A range of step-down facilities have been developed which champion a rehabilitation ethos and an intended outcome of returning clients home at the end of a short further period of recovery.

This plan provides continuity with the previous BCF plan. The COVID-19 pandemic accelerated the provision of hospital discharge services based on a "home-first" approach, which was already under way. Our priorities for 2023-25 and beyond are to continue the progress in the establishment of the integrated frailty service. This service is established to enable people to stay well, safe and independent at home for longer and to ensure that the right care is provided in the right place at the right time.

Governance

The Better Care Fund (BCF) plan evolved over a number of years as an element of the implementation of the North Tyneside Future Care strategy, shaped by the Future Care Programme Board which was our place-based planning mechanism. The Future Care Programme Board included representatives of the local NHS providers (acute, mental health and primary care), social care, primary care networks, the Council for Voluntary Service, North Tyneside Carers Centre, and the Community and Health Care Forum.



This Governance structure has continued under the place based arrangements within the North East and North Cumbria Integrated Care Board (referred to as the ICB) but arrangements are now in the process of being redeveloped.

The Health and Wellbeing Board (HWB) provides a shared vehicle for political, clinical, professional and community leaders of a place to develop a shared ambition for improving health and wellbeing and addressing health inequalities. This is undertaken through the joint strategic needs assessment (JSNA) and the agreement of the joint health and wellbeing strategy.

The HWB agreed a new Health and Wellbeing Strategy – 'Equally Well' in November 2021 which was the culmination of collaborative work to support the North Tyneside Mayor and Cabinet's policy priority to tackle the impact of the pandemic which amplified the inequalities across the borough. The strategy informed the development of the Northeast and North Cumbria Integrated Care Partnership (NENC ICP)– 'Better Health and Wellbeing for All' which was published in December 2022.

The HWB will continue to provide strategic leadership for the JSNA and delivery of the health and wellbeing strategy 'Equally Well'. However, a new officer led committee will be established in North Tyneside which will not only strengthen the current arrangements but also support the developing ICB at place.

The new committee will be established, known as the North Tyneside Health, Care and Wellbeing Executive and will provide an opportunity for meaningful collaboration, planning and improving health and care services, co-ordinating care and integrating services while proactively identifying and responding to population need. While those Executive members with delegated authority from the ICB Executive will undertake the statutory commissioning responsibilities, executive actions and decisions on behalf of the ICB Executive, it will also make decisions and take actions in relation to other shared local priorities within the delegated authority of its members.

North Tyneside Health, Care and Wellbeing Executive members with delegated authority from the ICB Executive will be accountable to the ICB Executive for those responsibilities delegated. It will also report directly to the North Tyneside Health and Wellbeing Board as the work of this committee will directly contribute to the delivery of the North Tyneside health and wellbeing strategy 'Equally Well' and in particular implementing the key priority of the strategy in relation to health and social care integration.

The Local Authority leads on ensuring housing strategy is contributing to integration with an updated Strategic Housing Market Assessment undertaken in 2021/22 to feed into requirements over the next five years. A Strategic Housing Group meets within the Local Authority with Directors of Adult Social Care, Commissioning and Investment and Housing jointly overseeing the development of sufficient and appropriate housing for residents with specific needs. A Specialist Housing Market Position Statement is being updated with input from health partners sought through the Better Care Fund governance processes ensuring place-based alignment with an integrated care approach.

Strategic management of the Disabled Facilities Grant sits with the Assistant Director of Integrated Services within North Tyneside Council (currently covered with interim arrangements) who works closely with the Director of Housing to ensure strategy lines up with overall Housing priorities. This senior post oversees the use of the grant and the way it can support people to remain independent at home, prevent admissions to hospital and remove barriers to effective and rapid discharge from hospital. This post is also responsible for the strategic and operational management of the local authority provided elements of CarePoint and works into the Ageing Well and Frailty sub groups of the Future Care Board. This postholder also sits on the

Better Care Fund Board in North Tyneside to ensure that the strategic direction around the use of the DFG is lined up with Better Care Fund objectives.

Northumbria Healthcare NHS Foundation Trust and Newcastle upon Tyne Hospital NHS Foundation Trust have been consulted on the approach to the BCF hospital discharge metrics.

The Better Care Fund Partnership Board includes senior representatives of the ICB and Local Authority. The Board defines the BCF plan based on national guidance and the place-based strategy which is driven by the Future Care Programme Board, and agrees and manages a Section 75 Agreement to give effect to the BCF plan.

The North Tyneside Health and Wellbeing Board authorises the BCF plan. It provides reports to enable scrutiny by the Adult Social Care, Health and Wellbeing sub-committee of the Overview and Scrutiny sub-committee.

National Condition 1: Overall approach to integration

The Future Care programme has a vision to deliver a patient centered sustainable health and social care system with a focus on:

- Self-care and preventing ill health
- Resilient communities and families
- People living longer and with better quality of life
- People staying as independent and as well as they can for as long as possible
- Those at the end of life to have support and care to enable them to live in the best way they can, taking into account their wishes, beliefs and values
- People dying with dignity in their chosen place of death
- A more resilient, responsive and financially stable health and social care system.
- High quality, fully integrated services
- High levels of people and staff satisfaction with services
- Evidence based practice and care models
- Reduced reliance on acute services and on bed based care
- Right Care, Right Place and Right Time including ensuring every decision about care is a decision about appropriate housing
- North Tyneside system is seen as a preferred place to work with high levels of wellbeing and satisfaction however, in line with national trends, recruitment and retention is concern.

This plan represents a natural progression from the previous plan, with some changes to take into account progress that has been made. Within the Future Care Programme, action is under way to further develop services for older people, which will lead to reconfiguration of some services included in the BCF, within the overall financial envelope set out in the BCF Plan.

Integration of Housing into the overall approach is improving with the Local authority Head of Housing becoming a member of the Health and Wellbeing Board. A review of the use of the Disabled Facilities Grant processes is underway including consideration of how our Housing assistance Policy can be further widened to provide maximise support to our residents to stay safe, well and independent at home for longer.

The Local Authority and the ICB work collaboratively on a number of initiatives linked to ensuring there are high quality services and support arrangements in place for the people of North Tyneside. We have seen increasing need for collaboration, joint working and integrated services to enable the system as a whole to meet the increasing health and social care needs of the borough.

Collaborative Commissioning

The Better Care Fund is a vehicle to support collaborative commissioning to ensure that the right services are in place to keep people safe and well at home freeing up health services and ensuring there is a good flow of people either out of hospital or preventing admission in the first place. Specific examples of this would includes the Local Authority leading on the commissioning of nursing placements, shared funding placements in the community and S117 mental health act funded placements for individuals following a detention for assessment and treatment in hospital under the Mental Health Act

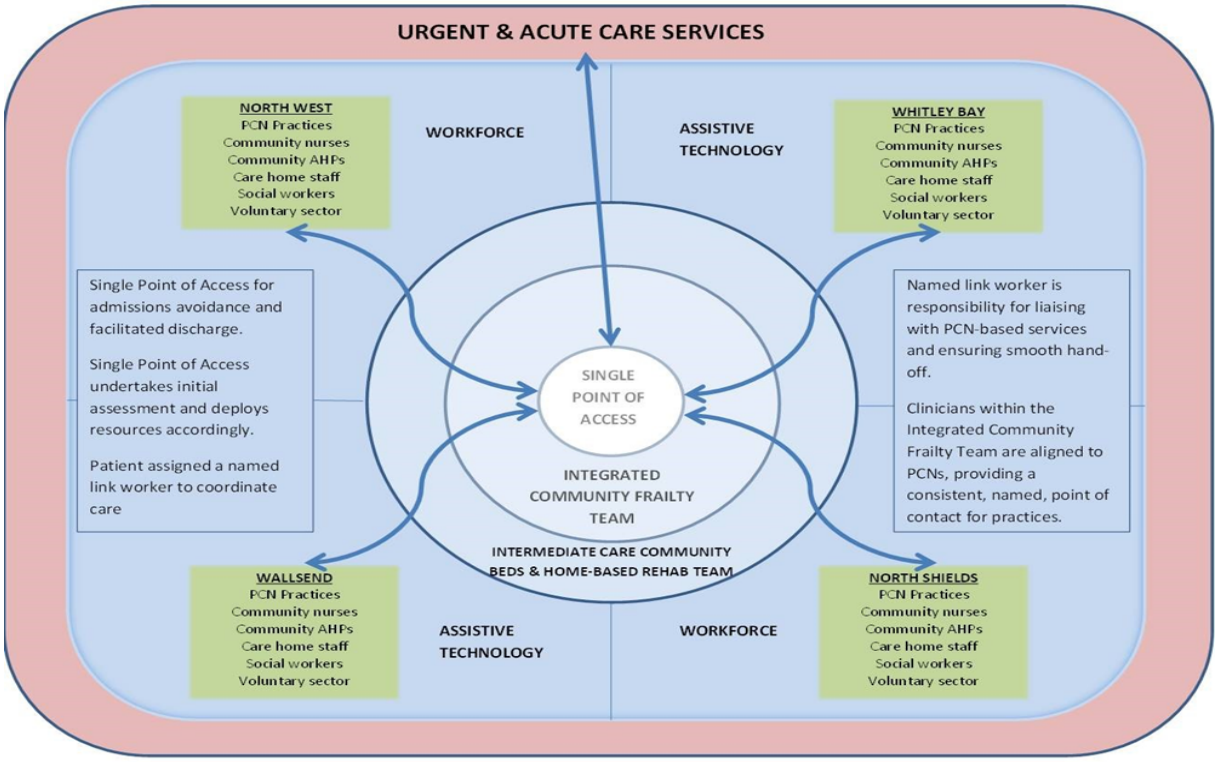
National Condition 2: Enabling People to stay well, safe and independent for longer

The Integrated Frailty Service

An Integrated Community Frailty Service for North Tyneside is being created through the reconfiguration of Care Point, Care Plus, Jubilee Day Hospital and intermediate care beds.

- The development of an integrated frailty service within existing NHS and Local Authority services contracts.
- The development of a new community bed based intermediate care facility at Backworth in North Tyneside, which will also house an integrated community frailty / aging well service, bringing together Care Point, Jubilee Day Hospital, and community bed based care under a shared management structure to provide a ‘one-stop-shop’ for frail elderly patients. Planning permissions have been obtained and building work is expected to commence in 2023/24.

Figure 1: Integrated Frailty service model



The key components of the planned model are:

- A single point of access and assessment, capable of understanding demand and deploying resources to avoid admission and facilitate rapid discharge.
- A single integrated community frailty team providing proactive and reactive, multidisciplinary assessment, interventions, rehabilitation, reablement and care planning for frail elderly patients in North Tyneside.
- All North Tyneside residents have rapid and equitable access to step-up and step-down beds, regardless of which local hospital they are accessing that care from.
- Coordination of care and closer alignment with community nursing teams, including mental health and Primary Care Networks.
- This service will consist of:
    - Single point of access
    - Integrated Community Frailty Team
    - Integrated Care community beds and reablement
    - Integration with primary care networks and community services

Single point of access

The single point of access will:

- Act as a true single access to the Integrated Community Frailty Service. This will end the current system whereby referrals can be made via Care Point or directly into individual services themselves.

- Assess the patient's needs and deploy the resources of the Integrated Community Frailty Team accordingly. This will include the assignment of a clinical link-worker who will take responsibility for coordinating the patient's care.
- Assess patients requiring access to community step-up and step-down beds.
- Replicate the 'back of house functions' of the existing Care Point service and the admissions avoidance and discharge planning resource funded under the BCF.
- Coordinate the alignment of the clinical and social care workforce within the integrated community frailty team to the localities, ensuring that there is a consistent, named, point of contact for practices and community nursing teams seeking guidance and support.
- Use technology to manage system wide community capacity and demand in real-time

Integrated community frailty team

The integrated community frailty team will bring together the teams currently delivering the following services:

- Jubilee Day Hospital
- Care Point 'front of house functions and teams'
- Enhanced CarePoint
- Community Falls Clinic (once existing contracts expire)

To provide:

- Single MDT-based assessment, diagnosis and management of frail elderly patients with the aim of enabling self-management, preventing further deterioration, avoiding admission and facilitating discharge.
- A person centred single assessment and care plan based upon CGA process
- Patients will also be assigned a clinical link worker to act as their main point of contact to ensure person centred care coordinated care delivery.
- Care will be delivered in the patient's place of residence or a community-based setting wherever possible, particularly for patients with more severe levels of frailty.
- The service will be accessed on an equitable basis which reflects the fact that approximately 40% of North Tyneside residents access acute care in Newcastle.

Intermediate care community beds and reablement

More care will be delivered in a community setting, with additional investment in community services and social care provision being used to support this transition. This will include:

- Creation of a new community-based facility capable of housing the Single Point of Access and the Integrated Community Frailty Team alongside the intermediate care beds.
- Creation of step-up community bed pathways to support admission avoidance and functions of the single point of access.
- Strengthening the role of the peripatetic service.
- Enhancing the role of Personal Independence Coordinator workers and volunteers

Integration with Primary Care Networks and community services

Patients and clinicians have both identified the need for a single named person to coordinate care and manage transition into and out of specialist frailty services. This ensures that patients will only have to “tell their story once” during a specific episode of care and that healthcare is delivered more efficiently by removing unnecessary duplication of assessment.

The Community Matrons that are currently deployed within Enhanced CarePoint will normally act as the named link-worker for the majority of patients referred into the Integrated Community Frailty Service. They will also act as the primary point of contact between the specialist frailty teams and the wider healthcare system, including practices, district nursing teams and hospital-based services.

In order to foster strong working relationships between the Community Matrons, GP practices and community services, the Community Matron workforce will be aligned to an existing locality of North Tyneside.

Other BCF services

In addition to the Integrated Frailty Service, the BCF supports a range of other developments:

Liaison Psychiatry for Working Age Adults provides an interface between psychiatry and medicine focusing on providing improved management for patients with co-morbid physical and mental health conditions.

Care Act implementation, Support for Carers, and Advice and Information support carers to maintain their caring role through good quality assessment and planning; support prevention through access to advice and information; ensure advocacy support is available; and help to ensure there is a viable and sustainable care market.

Hospice at home provides a rapid response end of life service to ensure all patients in non-palliative settings receive emergency palliative care trying to keep people in their place of choice, offering emotional and practical support for carers and family members as well as specialist input where needed.

Independent support for people with a learning disability provides support for people with a learning disability to maintain and increase their independence in the community.

Funded through the Improved Better Care Fund, are initiatives to support the social care provider market, through meeting the cost of paying the Living Wage to staff of social care providers, and of responding to increased volume and complexity of social care provision. The social care market, across the country, is facing severe workforce shortages and these provisions aim to prevent market failures which would have an impact on the ability to provide post-hospital discharge care.

Collaborative Commissioning

The Better Care Fund is a vehicle to support collaborative commissioning to ensure that people remain safe, well and independent at home. Specific examples of this are as follows:-

- The Adaptation and Loan Equipment Service and the Disabled Facilities Grant (both under the Better Care Fund arrangements) put in place services and environmental changes to support people at home
- The Authority leads on developing a range of housing solutions suitable for a variety of needs including extra care housing for older people and adapted housing for younger adults with physical or learning difficulties. A new recovery based supported housing option for adults with mental health issues has recently been developed to replace use of residential care.
- The work undertaken within the Frailty Pathway Group will deliver on a new Integrated Frailty Service for the borough with integrated provision and services

Anticipatory Care

Anticipatory care (AC) is a Long-Term Plan commitment focused on provision of proactive care in the community for multimorbid and frail individuals who would benefit most from integrated evidence-based care. Integrated Care Systems are expected to design, plan for and commission anticipatory care for their system. Systems need to work with health and care providers to develop a plan for delivering anticipatory care from 2023/24 in line with a national operating model for anticipatory care.

In North Tyneside, anticipatory care is part of the strategy for the development of the Integrated frailty service (Ageing Well). The Care Point service has been enhanced:

- Care point Health & Social care model with Reablement, Discharge to Assess, Hospital avoidance and planned pathway (48hour) and urgent crisis response (Nurse Practitioner) pathway part of 2 UCR. We are in the process of streamlining existing Care Point services and Jubilee Day Hospital into an integrated hub, which includes bed based intermediate care. We are developing "spokes" and Multi Disciplinary Teams within each Primary Care Network.
- We are deploying 16 Community Care Practitioners across the hub and spokes as part of this integrated frailty programme and are developing a model in community services for Long Term Condition management, including mapping demand and workforce planning to meet need. We have developed and costed a delirium at home model and are incorporating the Community Falls Clinic within the Integrated Frailty Service.

Strengths Based Approach

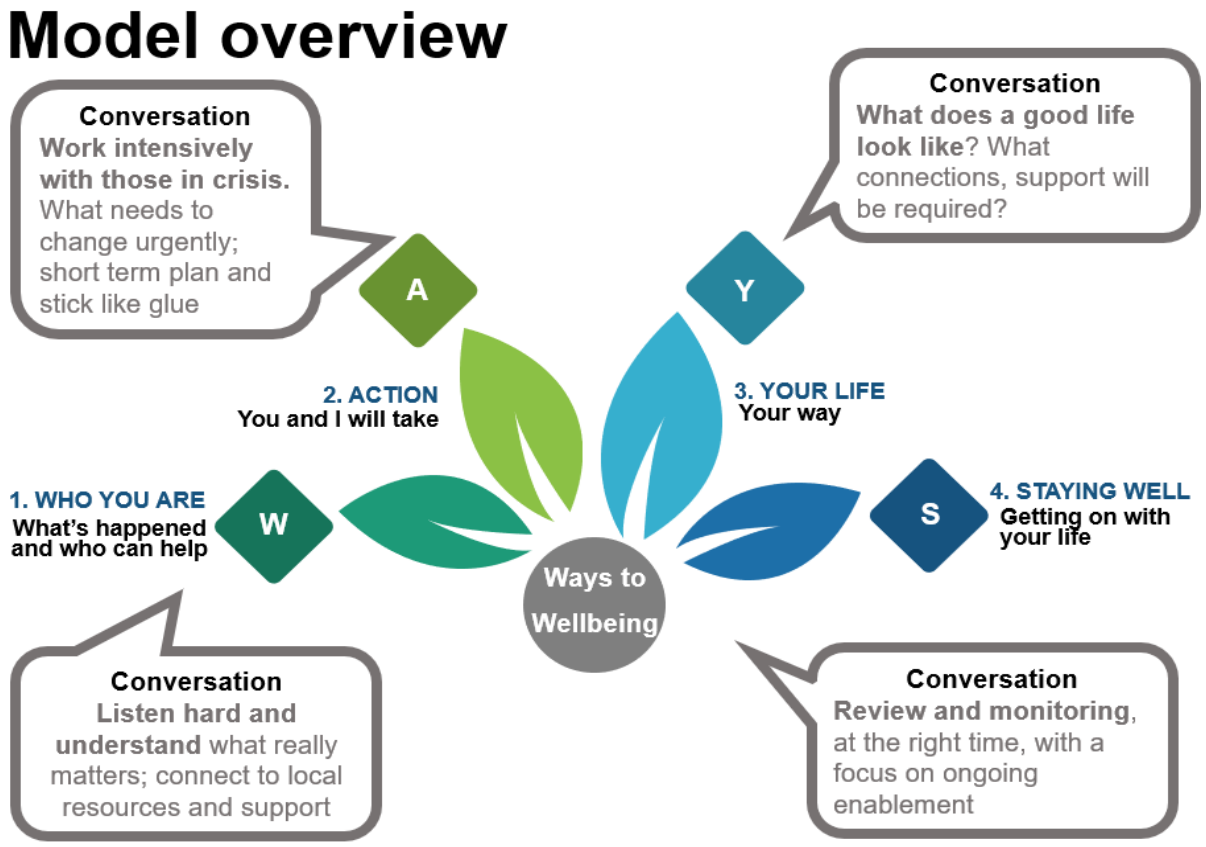
Our use of a strengths-based approach and person-centred care is shown by the development of the “Ways to Wellbeing” model within adult social care. This provides a practice model which;

- describes our approach to working with adults
- is values-based and transformative
- is responsive to challenges that our customers face
- provides consistent knowledge, tools and skills for staff
- enables great quality of practice

The underlying principles of the model are:

- Always start the conversation with the strengths of people, families and communities
- Always exhaust conversations 1 and 2 before conversation 3 (see Figure 1 below)
- Never make a long-term plan in a crisis
- Stick to people like glue during conversation 2 – support people to regain control of their life
- No hand-offs, no referrals, no waiting lists, no pending cases
- Listen to people – understand from their perspective
- Know the neighbourhoods and communities that people live in
- Work collaboratively with members of the community, networks, and support system
- Strengthen focus on maximising family support, and keeping people connected to communities
- Use **technology** wherever we can

Figure 1: The "ways to wellbeing" practice model



National Condition 3: Provide the right care in the right place at the right time

Supporting Hospital Discharge

The CarePoint service, funded through the BCF, and provided jointly by Northumbria Healthcare FT and North Tyneside Council, uses an interdisciplinary approach to achieve safe and efficient admission avoidance and discharge. The team has a holistic focus on the entire patient pathway from hospital to home. This proactive and preventative approach aims to ensure seamless transitions and help to avoid unnecessary admission and readmission to hospital. The response and care is coordinated across organisations involved; older people have a named coordinator. CarePoint has access to resource availability and has the authority to deploy accordingly based on the needs of the individuals and to ensure optimal utilisation of commissioned services. This will ensure that care and support interventions are provided at the right time; by the person with the most appropriate skills, in order to get the right care, first time, every time.

The services work together with a strong 'home first' ethos however shortages in homecare capacity and the acuity of needs of some patients has made discharges home more challenging.

New step-down services were introduced in 2022/23 funded through the Discharge Support Fund announced on 22 September 2022.

An additional 20 short term assessment beds (10 residential and 10 able to take clients with nursing needs) have been established for patients who are medically optimised

but who require a short period of convalescence whilst their future care needs are determined and/or who are unable to move to their future place of residence due to a delay in obtaining appropriate social care.

Extra Care step-down services with 14 beds identified with extra care schemes within the borough where patients can stay for a short period of time while they receive some support and reablement to help them return home. One of these schemes specialises in dementia and is suitable for patients with a cognitive impairment.

Funding within the Discharge Support Fund has been identified to increase capacity within homecare and smaller amounts have been identified to remove barriers to discharge around transport and welfare assistance. Funding has also been identified to provide programme management support to improve the efficiency and effectiveness of discharge pathways.

BCF also funds:

- the *Adaptations and Loan Equipment Service* to ensure that people have equipment that they need to recover at home following discharge, as well as to avoid admission.
- The *Care Call crisis response team* which provides telecare services to help avoid admission and maintain independence following hospital discharge. This service also provides a falls first responder service which diverts pressure from ambulance services.

Partners across the system are focussed on continuous improvement including self assessment against the High Impact Change Model and improvement work to ensure progress against the 100 Day Challenge. Actions improving flow and discharge are summarised below;

Improving flow:

- Trusts have in place Discharge Boards at which all potential discharges are discussed each morning in the Site Brief. Length of Stay meetings take place, the frequency of which depends on current system pressures
- Discharge lounges are either already in place or are being established and dedicated transport is in place to move patients between hospital sites.
- Trusts work to ensure prompt transfer from the discharge lounges (1 hr for pathway 0 and same day all others).
- Local authority discharge teams work very closely with Trusts to ensure that the onward transfer from discharge area is undertaken as promptly as possible (7 day basis), aiming to meet national requirements for the majority of patients to be transferred in 2 hrs or same day.
- Improvements in data availability with updates to the Acute and Community Daily Discharge Situation Reporting Questions provided.
- Social circumstances and care needs are included in the admission sections of all nursing and medical documentation. Community discharge teams are involved at the earliest opportunities where any level of complexity or ongoing care is required. Proactive assessment for referral to intermediate care settings take place.

- Full implementation of the Discharge to Assess model in line with discharge policy percentages are in place. Data is reviewed to ascertain if the national discharge funding had an impact on flow and to inform discussions with partners on the challenges in the systems and work towards solutions.
- Recruitment to specific posts is being considered where it has been identified that this will be of benefit such as a System Flow Coordinator post. Additional specialist care home support team staff, District Nursing staff and Community and Rehabilitation Team staff are being recruited where appropriate.

Improving discharge:

- Discharge action cards have been shared with and are used by all Care Point staff involved in the discharge process in North Tyneside.
- Systems are in place to identify where additional staff education or training would be appropriate e.g. knowledge of ward staff of right to reside criteria and system flow for patients, encouraging earlier planning for discharge.
- Collect home situation details on admission, communicate discharge process with families and carers (leaflets are available in the Policy)
- The 3 stage D2A model implemented (review, agree plan to transfer, follow up by assessment at home) is in place in North Tyneside
- Information on pathway 0 to pathway 3 - numbers, % and any reasons they didn't go home - is collated a minimum of 3 days per week but, when in surge, this is available daily
- The Local Authority work with Community & Voluntary sector organisations to ensure that service users and discharged patients have all of the necessary needs met e.g. food in their home, to enable them to return home safely
- North Tyneside has care home capacity and has developed good working relationships with care homes. As has happened in previous years, particularly during the COVID-19 pandemic, capacity is available to stand up more beds in addition to the 40 intermediate care beds already commissioned through the BCF. This includes capacity for patients who have received a COVID positive result.

Supporting Unpaid Carers

The Authority and the ICB recognise the value that unpaid carers have in supporting people to continue to live independently at home or in the community. Both organisations are also committed to ensuring that Young Carers in North Tyneside will be recognised as young people first and will be protected from undertaking inappropriate levels and types of caring; able to access the same opportunities as other young people; and their education and life-chances outcomes are supported.

The work that carers do is invaluable and often supports some complex and intensive individuals in some very difficult circumstances. Without these carers the individual may well be in hospital or in more permanent residential or nursing home care, often at a much higher cost to social care and health.

The provision of good quality advice and information and emotional support for carers is critical. Contingency planning and respite provision can be integral to enable carers,

whether they care for older relatives, people with learning disabilities, people with a mental health problem, or people with physical disabilities to continue to undertake their caring roles and continue to be a valued part of their community.

The Care Act 2014 placed additional duties and responsibilities on local authorities with regard to supporting carers. The provision of advice and information which needs to be timely and in an appropriate format was given a greater focus. The Care Act placed greater responsibility on local authorities to assess a carer's own needs for support; explore the outcomes that a carer wants to achieve in their daily life; and the impact of caring responsibilities on their desire and ability to work and to partake in education, training or recreational activities. The assessment process for carers is being refreshed to adopt the Ways to Wellbeing approach taking a strength based approach to assessing carers' needs.

The Partnership commissions North Tyneside Carers Centre to deliver services which play a vital role in supporting carers to continue their caring role. This support includes;

- Provision of general advice and support via a web offer, telephone, 121 sessions and drop in sessions across the Borough
- Statutory carers assessment on behalf on the Local Authority, in situations of complexity, conflicting needs, or where more intensive ongoing support may be required by the carer
- Light touch assessments to understand needs and offer tailored support.
- Advocacy support
- Overseeing volunteers who facilitate specialist and general peer support groups
- Links with specialist services e.g. Memory Clinic
- The delivery a programme of information and training sessions for carers in the community
- Working to develop and deliver specialist information and training sessions for carers
- Delivery of carer awareness training sessions for professionals

The service also works to raise the profile of carers through a web site, social media, local media and community events.

There is also a Young Carers Service in North Tyneside which aims is to improve and maintain the health and wellbeing of young carers by supporting improved awareness of the issues young carers and their families face and to build capacity within services across the borough to increase identification and to support the with the implementation of the young carers' statutory assessment.

During 2022/23, in excess of 5000 carers were supported by North Tyneside Carers' Centre.

Respite / Short-break services

The support many carers require involves a service delivered to the person they care for including residential short break and respite services and forms of domiciliary care and day care. Other forms of support are often provided by access to a peer support

group, training or being provided with advice and information on the condition of the person being cared for. Funding from the BCF allocation is used to support the cost of these services.

There are a number of contracts in place with independent and voluntary sector providers for the provision of respite, day services and sitting services which allow carers to take a break from their caring role and put contingency arrangements in place if a carer was unable to undertake their caring role in an emergency.

Disabled Facilities Grant (DFG) and wider housing services

Appropriate housing is recognised as a key factor in ensuring people can stay safe, well and independent at home. The system has invested in a wide range of housing options including extra care and independent supported living facilities which cater for a wide range of needs including learning disabilities, physical disabilities, autism and mental health issues. Appropriately adapted housing can reduce or even eliminate the need for care improving outcomes and independence for the individual. The Better care fund contributes to funding the costs of these housing options. Our occupational therapists will always consider alternative housing options before looking at the potential to adapt an existing home through a disabled facilities grant (DFG) application.

The DFG aims to:

- Enable people to live independently in their own home
- Minimise risk of injury for customer and carer
- Prevent admission to hospital and long term care
- Reduce dependency upon high level care packages
- Improving quality of life and well being
- Maintain family stability
- Improve social inclusion
- Enhance employment opportunities of the disabled person
- Support the local economy

Cabinet last agreed a policy on the use of the Disabled Facilities Grant in March 2018, in line with the Regulatory Reform Order 2002. We are currently considering widening the policy to be able to better support our residents safely at home. The current policy outlines the following uses for the grant:-

- Any adaptation that costs less than £10,000 will not involve a means test allowing adaptations to be delivered quicker, expediting hospital discharge, reducing care package costs, and preventing admission to hospital or residential settings.
- The Grant can be used to remove a Category 1 Hazard under the Housing Health and Safety Rating System, where there is assess need. This national system for assessing risk in homes defines a Category 1 Hazard as one posing a serious threat to people living in or utilising a home (for example poor wiring or heating). In line with national best practice, local housing need and the experience of our healthy homes work, the evidence shows that this will allow improvements to poor quality owner-occupied or rented property where the resident has an assessed need to prevent escalation of that need and further care costs

- The upper ceiling of the Grant was increased from £30,000 to £40,000;
- The Grant can be used in specific cases for homes out of North Tyneside, where the Council is responsible for care costs.
- The Grant will be used for equipment to meet assessed need; over time, the overlap between “equipment” and “adaptation” has become greater. The policy will allow the Grant to be used for items of equipment, where that item is specific to assessed need and can be seen to prevent additional care costs
- The Grant will allow for maintenance of the asset, for example by including maintenance arrangements in the initial price.
- The Grant will be used to support people who chose to move home in order to live independently. This use of the Grant will secure a better outcome to assess need; represents better value than adaptation; can be used when adaptation of the current home is not practical, and can avoid a more expensive care arrangement (for example, admission to residential care).

North Tyneside Council actively seeks to target the Grant in order to make the most difference:

- In terms of people; children with assessed needs, young adults with a lifelong disability, and older people seeking to continue independent living are most likely to benefit from the Grant.
- In terms of housing types; experience and practical delivery shows that bungalows, ground floor flats, homes with large downstairs spaces, and homes with outhouses or garages can best be adapted.
- In terms of places; this work is done with an eye to creating a longer term asset, improving poor quality housing and places with access to local amenities and public transport, which promotes independent living.

Equality and health inequalities in North Tyneside – CORE20PLUS5

In North Tyneside, the Equally Well Strategy is being developed, which is a system-wide plan at place to improve the health and wellbeing of our population. It builds on the previous strategy and existing work to reduce inequalities in the Borough and initially outlines the approach for the next 4 years

The North Tyneside Health and Wellbeing Board is responsible for the strategy, which has been developed by its representative partners and will shape and inform plans for commissioning and providing services that address the wider determinants of health and reduce inequalities.

Engagement with our Voluntary, Community and Social Enterprise sector (VCSE), residents, young people, elected members and health and care professionals has also been carried out to identify work that is already happening and current challenges. This engagement will continue to be important in the detailed implementation plan for the strategy.

The approach within the strategy is based on the up-to-date evidence of how best to effectively reduce inequalities and is informed by the considerable work led by Sir Michael Marmot and the Institute of Health Equity.

Part of our Future Care Plan is population health management. We have agreed in our Plan a number of objectives for the next few years, focussing on reducing health inequalities and unwarranted variation in health outcomes through stronger action by all NHS partners at a local level (Foundation Trusts, primary care, Primary Care Networks (PCNs), ICBs) to deliver actions contained within Joint Health and Wellbeing Strategies and Health and Wellbeing Boards. We will build upon existing partnerships and we continue to develop a whole systems approach for tobacco, alcohol, substance misuse, obesity and sexual health. We continue to build the capacity of our population to self-care including embedding social prescribing across the system and to increase public health capacity and skills (including Making Every Contact Count (MECC) and brief interventions) within the NHS in order to support the move from reactive care towards a model of NHS services that embodies population health. We also recognise the role of the NHS in tackling the wider determinants of health, for example through action on air pollution, its contribution to the local economy, improved access to employment for those from highest areas of deprivation, and promotion of green spaces to increase physical activity.

A number of initiatives and programmes are underway in North Tyneside to achieve our objectives:

- Better Together Programme across health, the local authority and the VCS, and have introduced a grant scheme in recognition of the important role that voluntary and community sector organisations play. The schemes provide support into deprived communities in North Tyneside. This includes provision of support for families with low income, for refugees and for homeless people.

- Working within the Carers partnership in North Tyneside, we are piloting a Carers Passport scheme within a hospital setting, to improve the identification, recognition and support for carers and also piloting a carers support worker role within hospital settings. Additionally, Healthwatch North Tyneside and North Tyneside Carers Centre to undertake research to understand carers experiences and issues.

- Every household in North Tyneside received a copy of a HOWfit leaflet to ensure equity and maximise the impact of people undertaking the exercise and health and wellbeing contained within the leaflet. It offers general advice on physical activity and is aimed at adults who could benefit from simple exercise and activity to reduce the impact of a sedentary lifestyle and for those at risk of falls.

- We have a dedicated nursing team in North Tyneside ICB providing support to care homes. All care homes in North Tyneside have been provided with the Whzan News kits for undertaking clinical observations and recording of the NEWS2 score. Homes received training on the use of the Whzan kit. This helps establish what clinical interventions might be required and can be communicated to relevant health professionals.

- The 4 Primary Care Networks in North Tyneside (North West, Wallsend, North Shields, Whitley Bay) and have collaborated to deliver a range of objectives

around extended hours access, access to clinical pharmacy and development of social prescribing initiatives. Living Well North Tyneside has also been established with the 4 Primary Care Networks, to make health and wellbeing information easier to find and access online. Social prescribing and care navigators are available to help people through primary care networks and access appropriate levels of support

The Better Care Fund Board regularly monitors the impact of services against the protected characteristics of the residents in North Tyneside who use the services.

Figure 3 below shows the age spread of clients who received reablement in 2022/23.

Figure 3: Age bands of clients receiving reablement

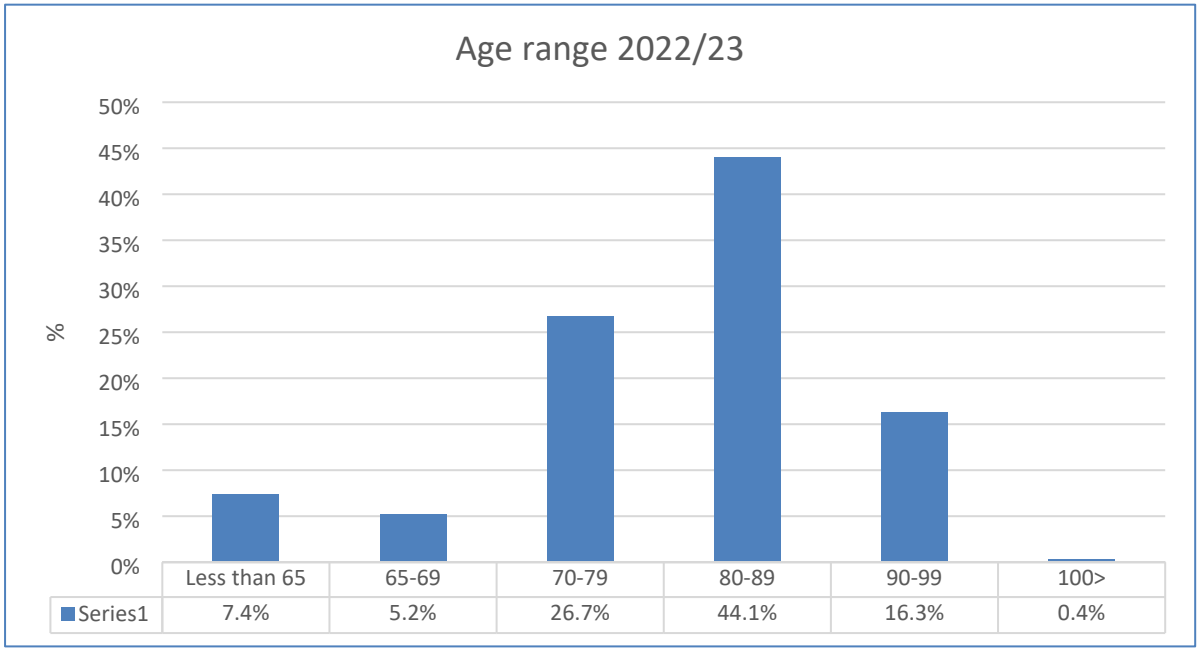


Figure 4 below shows that ethnic minority patients are slightly more likely than white patients to be discharged from hospital to their usual place of residence.

Figure 4: Percentage of hospital patients who are discharged to their usual place of residence, by ethnic origin. Source: NHS Digital BCF Data Pack v2

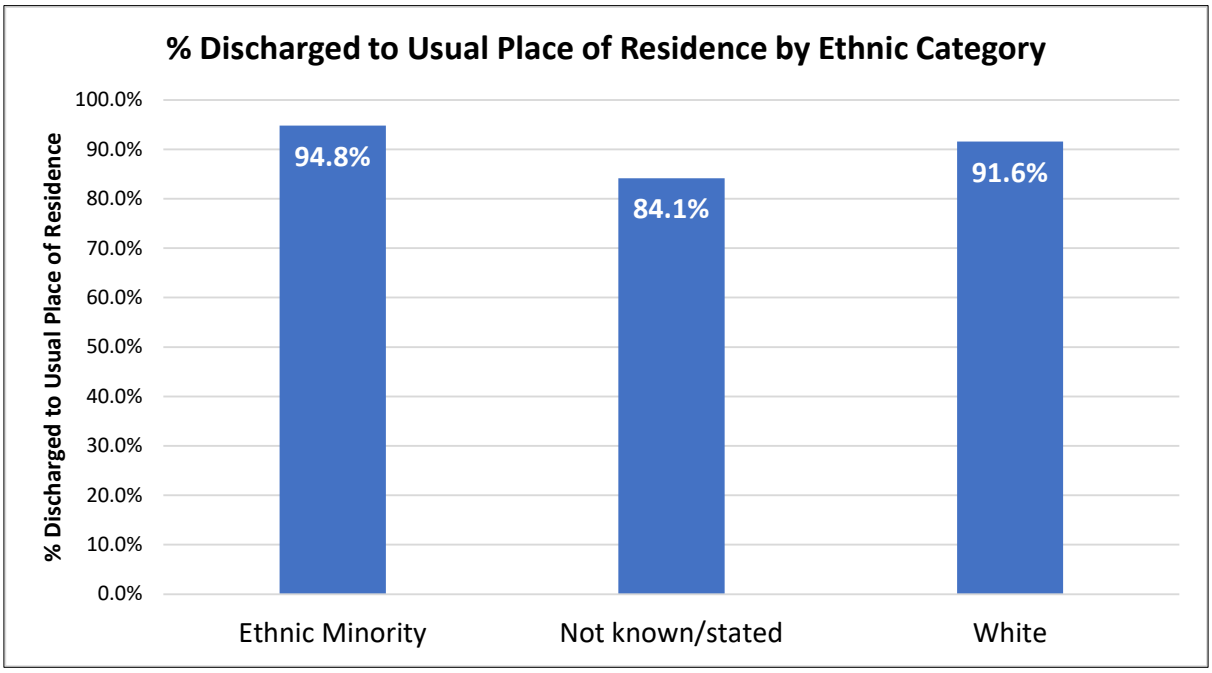
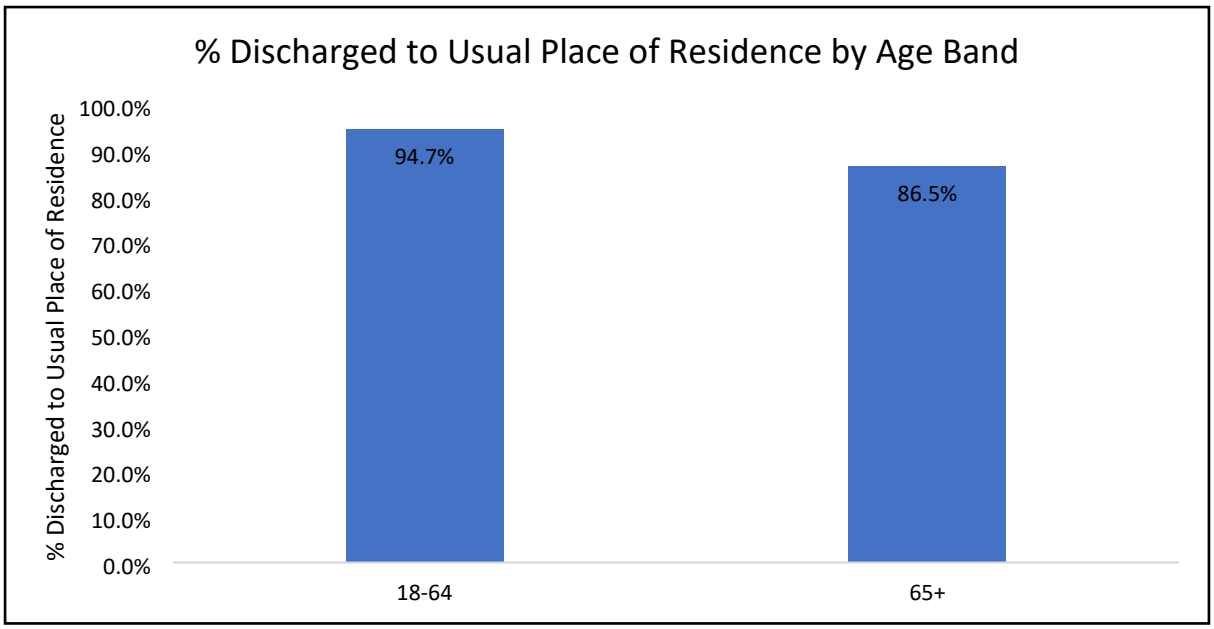


Figure 5 shows that the probability of being discharged to usual place of residence declines with age. The majority of our BCF services are focused on older people in response to the growing levels of need in the older age groups.

Figure 5: Percentage of hospital patients discharged to their usual place of residence. by age bands. Source: Secondary Uses Service



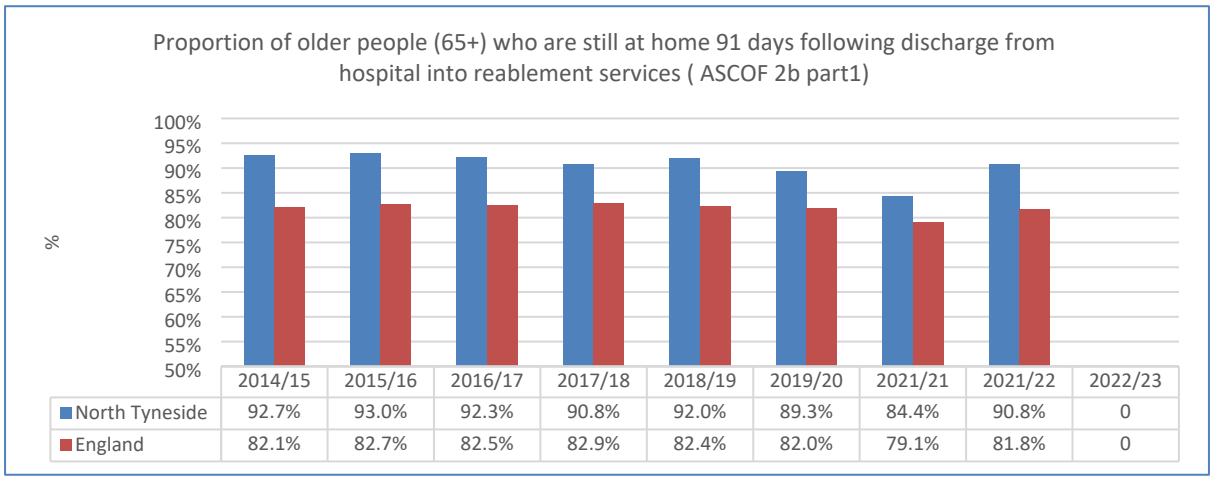
Appendix 1 - BCF Metrics

This section outlines current performance against the national BCF metrics and explains our level of ambition.

1 Effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)

Figure 6 below shows that North Tyneside has consistently performed on this metric well above the England average. Locally and nationally, performance was impacted by the COVID-19 pandemic in 2020/21; the North Tyneside rate reduced to 84.4% but remained above the England average. Performance in 2021/22 was 90.8% returning to pre-Pandemic levels and was well above the England average of 81.8% however performance has dropped in 2022/23 to 83% as a result of a higher than usual number of deaths and admissions to residential care. This result reflected the general deterioration in condition of the clients being referred into the service. We have retained the target for 2023/24 at 90.0% with the aim of returning to the previous level of performance while ongoing work progresses to establish whether there has been a longer term shift in the condition of clients entering the service. The service has undergone restructuring to provide an optimum skill mix and provide career development opportunities for staff to progress within the service.

Figure 6: Effectiveness of reablement metric, time series



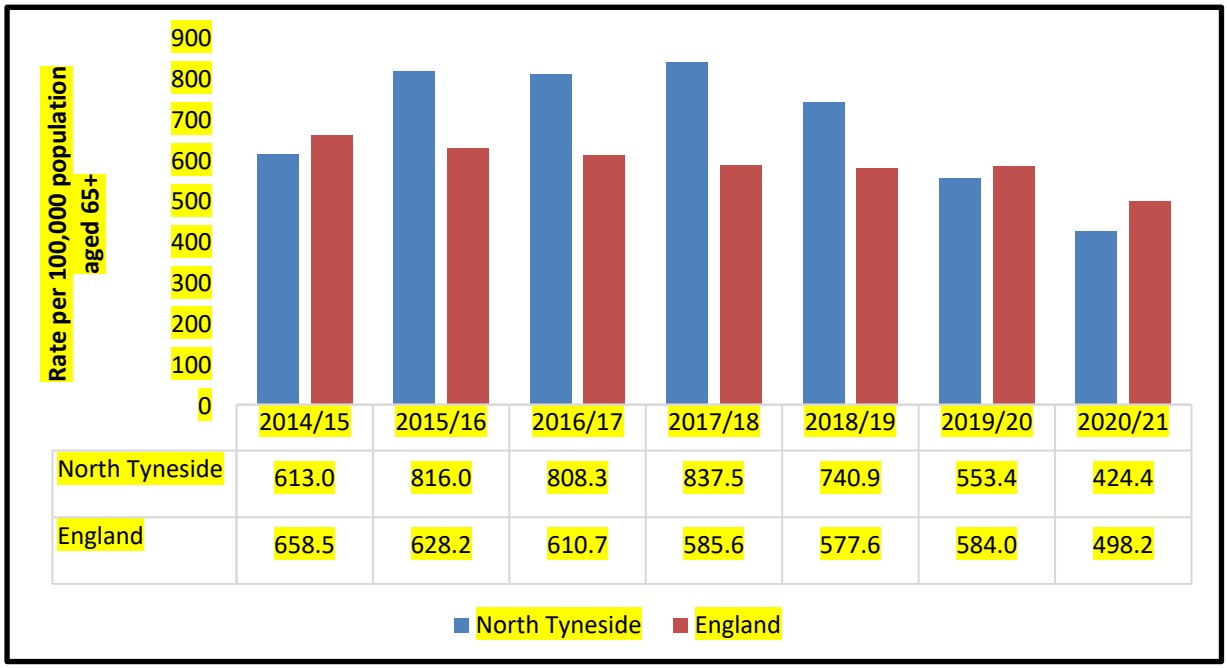
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2021/21	2021/22	2022/23
North Tyneside	92.7%	93.0%	92.3%	90.8%	92.0%	89.3%	84.4%	90.8%	0
England	82.1%	82.7%	82.5%	82.9%	82.4%	82.0%	79.1%	81.8%	0

2 Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

Figure 7 shows that North Tyneside has historically had a greater than average reliance on permanent residential care for older people but this reduced to below the England average in each of the last three financial years. In 2020/21 and 2021/22, the outturn was influenced by the COVID-19 pandemic and shortages of capacity in homecare resulting from workforce recruitment and retention issues, which led to a greater proportion of patients being discharged from hospital into short term residential care, funded for a period through the NHS post-discharge funding arrangements. A significant proportion of these short term placements have now become long term and are counted within this metric. The shortages in homecare capacity have continued in 2022/23 as has the pressure to maintain hospital flow by facilitating efficient

discharges. This, combined with a generally more complex cohort of people being discharged from hospital, has lead to a further increase in use of residential care

Figure 7: Time series of permanent admissions to residential care for persons aged 65+, per 100,000 population aged 65+



For 2023/24 we expect the outturn to be 762.7 admissions per 100,000 people aged 65+ delivering a 5% improvement on the estimated outturn for 2022/23 which will be challenging to deliver as capacity issues remain in the homecare market in line with national trends despite local and regional measures to improve workforce recruitment and retention.

BCF services will impact this goal through:

- The continued operation of the CarePoint service, promoting a Home First response to hospital discharges, and it's development as an element of the Integrated Frailty Service
- The provision of the Adaptations and Loan Equipment Service, which helps people to maintain their independence at home.
- Additional step down facilities with the aim of people returning home after a further period of recovery

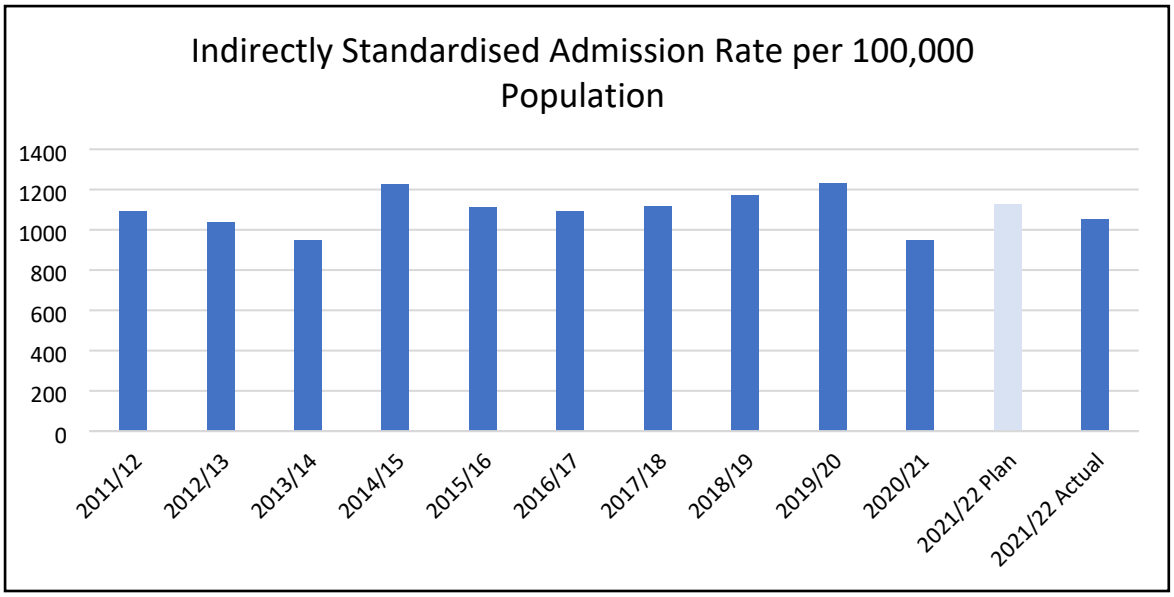
Other developments, not part of the BCF scope, will impact as follows:

- There are 11 extra care schemes across North Tyneside with 479 apartments. Most of these are rental but a small number are shared ownership. Extra care offers individuals the ability to continue to live in the community, at home and have access to on-site care and support through a 24/7 commissioned care team. All apartments are self-contained and individuals are supported to maximise the maintain their independence.

3 Avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions).

Figure 8 below shows a time-series of unplanned hospitalisation for chronic ambulatory care sensitive conditions, expressed as an indirectly standardised rate per 100,000 people. In 2022/23 North Tyneside's estimated outturn performance of 1139 was 9% short of the target of 1044.

Figure 8: Standardised admission rate of chronic ambulatory care sensitive conditions



Our ambition for 2023/24 is a rate of 1115 which is the forecasted average performance in the north of our region for 2022/23. This would represent a 2% improvement on our 2022/23 outturn.

BCF services will impact this goal by:

- Enhanced care in care homes continues to improve the planning and delivery of healthcare for care home residents, maintains and enhances the quality of care, and increases the number of healthcare interventions that are carried out in a care home setting, hence reducing the number of unplanned admissions to secondary care from nursing and residential care homes.
- The provision of support to carers reduces the number of cases where carer breakdown results in an unplanned hospital admission and the more holistic approach to carers assessment using the Ways to Wellbeing model will further strengthen this effect in 2023/24.
- The provision of high quality discharge planning by CarePoint (an element of the Ageing Well service) reduces the probability of readmission following a sub-optimal discharge.

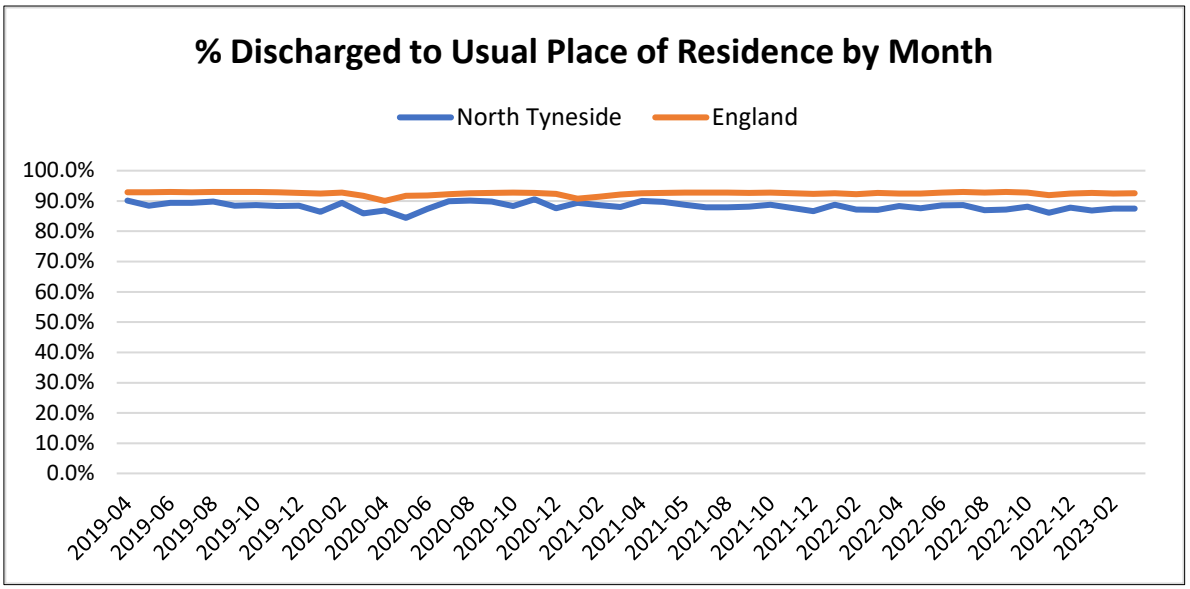
Other developments, not part of the BCF scope, will impact as follows:

- The increasing use of a Same Day Emergency Care (SDEC) approach – also known as ambulatory care - is a key component of the approach to reducing unplanned admissions. It aims to minimise and remove delays in the patient pathway allowing services to process emergency patients within the same day as an alternative to hospital admission
- Our urgent and emergency care action plan notes that a number of projects are in place to improve hospital flow and discharge, including a review of the current Same Day Emergency Care clinical models to identify opportunities to increase or expand SDEC where appropriate.
- Virtual ward has now been established for frailty and continues to develop

4 *Percentage of people who are discharged from acute hospital to their normal place of residence.***Error! Reference source not found.**

Figure 9 below shows the proportion of people discharged to their normal place of residence from April 2019 to March 2023. The rate for North Tyneside was below the England average throughout the period, by an average of approximately 4%.

Figure 9: % discharged to usual place of residence, North Tyneside compared to England



We are aware that our main acute trust codes patients who normally live in a care home and are discharged back to that care home as not discharged to their normal place of residence. We understand that many Trusts code this outcome as discharge to normal place of residence. If we adjust for this difference out estimated outturn for 2022/23 is 91.5% compared to an unadjusted value of 87.6%. we intent to retain a target of 90% in line with 2022/23.

BCF services will impact this goal by:

- The continued operation of the CarePoint service, promoting a Home First response to hospital discharges, and its development as an element of the Integrated Frailty Service

- The provision of the Adaptations and Loan Equipment Service, and the use of the Disabled Facilities Grant, which helps people to maintain their independence at home.

5 *Emergency hospital admissions due to falls in people aged 65+*

There was an improvement between 2021/22 and 2022/23 despite residents presenting later with more complex needs. We are aiming for a 3% improvement on 2022/23

Figure 10: Trend in Falls admission rates for 65+

Year	Directly Standardised Admission Rate per 100,000 Population
2016/17	2733.1
2017/18	3028.6
2018/19	2939.2
2019/20	3321.9
2020/21	3075.9
2021/22	3215.5
2023/23 FOT*	3171.1

Local falls service consisting of a falls pathway with specialist clinic, local exercise campaign and support. A telecare service responding to falls including non injurous falls referred by ambulance service is funded through the BCF.

Appendix 2 – BCF services and expenditure

Scheme ID	Scheme Name	Brief Description of Scheme	Area of Spend	Source of Funding	Expenditure (£)
1	Community--based support	Includes Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; CareCall/telecare including falls first responder; and seven-day social work	Social Care	Minimum ICB Contribution	9,626,722
27	Community-based support	Health contribution to CarePoint	Community Health	Minimum ICB Contribution	2,674,747
2	Intermediate Care beds	Intermediate Care	Community Health	Minimum ICB Contribution	3,616,877
3	Intermediate Care - Community Services	Community Rehabilitation Team	Social Care	Minimum ICB Contribution	963,456
4	Liaison Psychiatry - Working Age Adults	Liaison Psychiatry - Working Age Adults	Mental Health	Minimum ICB Contribution	858,351
19	End of Life Care - RAPID	End of Life Care	Community Health	Minimum ICB Contribution	262,987
8	Improving access to advice and information	MyCare and Living Well in North Tyneside digital services	Social Care	Minimum ICB Contribution	40,355
9	Care Act implementation	Care Act implementation	Social Care	Minimum ICB Contribution	825,131
10	Carers Support	Carers Support	Social Care	Minimum ICB Contribution	749,107
12	Independent Support for People with Learning Disabilities	Independent Support for People with Learning Disabilities	Social Care	Minimum ICB Contribution	802,614
13	Impact on care home fees of	Meet costs of paying living wage	Social Care	iBCF	2,718,395

Scheme ID	Scheme Name	Brief Description of Scheme	Area of Spend	Source of Funding	Expenditure (£)
	national living wage	to staff in care homes			
14	Impact on domiciliary care fees of national living wage	Meet costs of paying living wage to staff of home care providers	Social Care	iBCF	865,017
15	Impact on other increased fees (ISL, day care, direct payments, etc) of national living wage	Meet costs of paying living wage to staff of other social care providers	Social Care	iBCF	4,037,099
16	Effect of demographic growth and change in severity of need	Increased volume and complexity of social care provision	Social Care	iBCF	1,958,003
	Step down beds - residential	Provision of 10 additional step down residential care beds	Social Care	Discharge Funding LA	557,409
	Step down – extra care	Provision of additional extra care beds for short term use	Social Care	Discharge Funding LA	504,775
	Build homecare capacity	Support the development of additional homecare capacity	Social Care	Discharge Funding LA	209,855
	Implement trusted assessor model	Implement trusted assessor model	Social Care	Discharge Funding LA	39,698
	Pathway development	Project management to improve the efficiency and effectiveness of discharge pathways	Social Care	Discharge Funding LA	31,156
	Step down beds - nursing	Provision of 10 additional step down nursing care beds	Social Care	Discharge Funding ICB	557,409
	Pathway development	Project management to improve the efficiency and	Social Care	Discharge Funding ICB	31,156

Scheme ID	Scheme Name	Brief Description of Scheme	Area of Spend	Source of Funding	Expenditure (£)
		effectiveness of discharge pathways			
	Step down beds extra care	Provision of additional extra care beds for short term use	Social Care	Discharge Funding	153,725
	Voluntary sector support for pathway 0 discharges	Commission additional low level support for non complex discharges	Social Care	Discharge Funding ICB	35,000
	Additional transport services to support discharges	Additional transport services to support discharges	NHS	Discharge Funding ICB	86,366
26a	Disabled Facilities Grant	Disabled Facilities Grant	Social Care	DFG	1,869,024
26b	Disabled Facilities Grant carry forward	Disabled Facilities Grant carry forward	Social Care	DFG	1,257,308
TOTAL					35,331,742

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Complete:
Health and Wellbeing Board:	North Tyneside	Yes
Completed by:	Sue Graham	Yes
E-mail:	sue.graham@northtyneside.gov.uk	Yes
Contact number:	07753 113741	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	<Please Select>	No
If no please indicate when the HWB is expected to sign off the plan:		No

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Ms	Karen	Clark	karen.clark@northtynesdie.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Ms	Sam	Allen	s.allen24@nhs.net	Yes
	Additional ICB(s) contacts if relevant	Ms	Anya	Paradis	a.paradis@nhs.net	Yes
	Local Authority Chief Executive	Mr	Paul	Hanson	paul.hanson@northtyneside.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)	Mrs	Eleanor	Binks	eleanor.binks@northtyneside.gov.uk	Yes
	Better Care Fund Lead Official	Ms	Sue	Graham	sue.graham@northtynesde.gov.uk	Yes
	LA Section 151 Officer	Mr	Jon	Ritchie	jon.ritchie@northtyneside.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: North Tyneside

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,869,024	£1,869,024	£1,869,024	£1,869,024	£0
Minimum NHS Contribution	£20,420,347	£21,576,138	£20,420,347	£21,576,138	£0
iBCF	£9,578,514	£9,578,514	£9,578,514	£9,578,514	£0
Additional LA Contribution	£1,257,308	£0	£1,257,308	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,342,893	£2,238,155	£1,342,893	£2,238,155	£0
ICB Discharge Funding	£863,656	£1,439,266	£863,656	£1,439,266	£0
Total	**£35,331,742**	**£36,701,097**	**£35,331,742**	**£36,701,097**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£5,802,883	£6,131,326
Planned spend	£7,412,962	£7,832,535

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£13,007,385	£13,743,603
Planned spend	£13,007,385	£13,743,603

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	282.0	246.0	303.0	284.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	3,171.0	3,171.0
	Count	1370	1370
	Population	43213	43213

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	90.0%	90.0%	90.0%	90.0%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	497	763

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: North Tyneside

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Average hours for a short term extra care step down packge is 15 hours per week Length of stay Reablement in a bedded setting - 28 days Length of stay Rehabilitation in a bedded setting - 26 days

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	67	67	67	67	67	67	67	67	67	67	67	67

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Reablement at home (pathway 1)	24	24	24	24	24	24	24	24	24	24	24	24
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		104	104	104	104	104	104	104	104	104	104	104	104
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	37	37	37	37	37	37	37	37	37	37	37	37
OTHER		2	2	2	2	2	2	2	2	2	2	2	2
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		43	43	43	43	43	43	43	43	43	43	43	43
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	16	16	16	16	16	16	16	16	16	16	16	16
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		20	20	20	20	20	20	20	20	20	20	20	20
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	7	7	7	7	7	7	7	7	7	7	7	7
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		11	11	11	11	11	11	11	11	11	11	11	11
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	4	4	4	4	4	4	4	4	4	4	4	4
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		22	22	22	22	22	22	22	22	22	22	22	22
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	8	8	8	8	8	8	8	8	8	8	8	8
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST		7	7	7	7	7	7	7	7	7	7	7	7
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST		2	2	2	2	2	2	2	2	2	2	2	2
OTHER		0	0	0	0	0	0	0	0	0	0	0	0

3.2 Demand - Community

Demand - Intermediate Care												
Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	140	140	140	140	140	140	140	140	140	140	140	140
Urgent Community Response	0	0	0	0	0	0	0	0	0	0	0	0
Reablement at home	29	29	29	29	29	29	29	29	29	29	29	29
Rehabilitation at home	14	14	14	14	14	14	14	14	14	14	14	14
Reablement in a bedded setting	7	7	7	7	7	7	7	7	7	7	7	7
Rehabilitation in a bedded setting	6	6	6	6	6	6	6	6	6	6	6	6
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge													Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	30	30	30	30	30	30	30	30	30	30	30	30		100%	
Reablement at Home	Monthly capacity. Number of new clients.	61	61	61	61	61	61	61	61	61	61	61	61		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	26	26	26	26	26	26	26	26	26	26	26	26		100%	
Short term domiciliary care	Monthly capacity. Number of new clients.	12	12	12	12	12	12	12	12	12	12	12	12		100%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.	26	26	26	26	26	26	26	26	26	26	26	26		100%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	52	52	52	52	52	52	52	52	52	52	52	52	100%		
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	30	30	30	30	30	30	30	30	30	30	30	30		100%	

3.4 Capacity - Community

Capacity - Community													Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	140	140	140	140	140	140	140	140	140	140	140	140		100%	
Urgent Community Response	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Reablement at Home	Monthly capacity. Number of new clients.	20	20	20	20	20	20	20	20	20	20	20	20		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	9	9	9	9	9	9	9	9	9	9	9	9		100%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: North Tyneside

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
North Tyneside	£1,869,024	£1,869,024	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£1,869,024**	**£1,869,024**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
North Tyneside	£1,342,893	£2,238,155	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS North East and North Cumbria ICB	£863,656	£1,439,266	Yes
Total ICB Discharge Fund Contribution	£863,656	£1,439,266	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
North Tyneside	£9,578,514	£9,578,514	Yes
Total iBCF Contribution	**£9,578,514**	**£9,578,514**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
North Tyneside	£1,257,308	£0	DFG carry forward	Yes
Total Additional Local Authority Contribution	**£1,257,308**	**£0**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North East and North Cumbria ICB	£20,420,347	£21,576,138
Total NHS Minimum Contribution	**£20,420,347**	**£21,576,138**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£20,420,347**	**£21,576,138**	

Yes

	2023-24	2024-25
Total BCF Pooled Budget	**£35,331,742**	**£36,701,097**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: North Tyneside

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£1,869,024	£1,869,024	£0	£1,869,024	£1,869,024	£0
Minimum NHS Contribution	£20,420,347	£20,420,347	£0	£21,576,138	£21,576,138	£0
iBCF	£9,578,514	£9,578,514	£0	£9,578,514	£9,578,514	£0
Additional LA Contribution	£1,257,308	£1,257,308	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,342,893	£1,342,893	£0	£2,238,155	£2,238,155	£0
ICB Discharge Funding	£863,656	£863,656		£1,439,266	£1,439,266	£0
Total	**£35,331,742**	**£35,331,742**	**£0**	**£36,701,097**	**£36,701,097**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,802,883	£7,412,962	£0	£6,131,326	£7,832,535	£0
Adult Social Care services spend from the minimum ICB allocations	£13,007,385	£13,007,385	£0	£13,743,603	£13,743,603	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87

									Planned Expenditure									
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Impact on care home fees of national living	meet costs of paying national living wage to staff in care homes	Residential Placements	Care home	meet costs of paying national living wage to	0	0	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£2,718,395	£2,718,395	8%
2	Impact on domiciliary care fees of national	Meet costs of paying real living wage to staff in homecare providers	Home Care or Domiciliary Care	Domiciliary care packages	Meet costs of paying real living wage to staff in	0	0	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£865,017	£865,017	2%
3	Impact on other fees (ISL, day care, direct payments etc) of national living wage	meet costs of paying national living wage to staff in care providers	Community Based Schemes	Other	meet costs of paying national living wage to staff in care providers				Social Care		LA			Private Sector	iBCF	Existing	£4,037,099	£4,037,099	11%
4	Effect of democratic growth and change in acuity of need	increased volume and complexity in care provision	Community Based Schemes	Other	increased volume and complexity in care provision				Social Care		LA			Private Sector	iBCF	Existing	£1,958,003	£1,958,003	6%
5	Community based support	includes Carepoint, reablement,immediate response and overnight	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£9,626,722	£10,171,593	100%
6	Intermediate Care - commmunity based	Community Rehabilitation Team	Home-based intermediate care services	Rehabilitation at home (to support discharge)		400	400	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£963,456	£1,017,988	100%
7	Improving Access to advice and Information	Mycare and Living Well in North Tyneside	Prevention / Early Intervention	Other	web based support providing				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£40,355	£42,640	10%

8	Care Act Implementation	Maintaining the duties and eligibilities brought in by the Care Act	Care Act Implementation Related Duties	Other	Maintaining the duties and eligibilities				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£825,131	£871,833	50%
9	Carers Support	Carers Support	Carers Services	Carer advice and support related to Care Act duties		5000	5000	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£749,107	£791,507	20%
10	Independent Support for people with a learning	independent support for people with a learning disability	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£802,614	£848,042	2%
11	Community Based Support	Health contribution to single point of access Carepoint	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£2,674,747	£2,826,137	100%
12	Intermediate Care beds	bed based intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		40	40	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£3,616,877	£3,821,592	100%
13	Liaison Psychiatry	Liaison Psychiatry - working age	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£858,351	£906,934	100%
14	End of life care - RAPID	End of life care	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£262,987	£277,872	10%
15	Step down beds - residential	Step down beds - residential	Residential Placements	Care home		10	10	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge	Existing	£557,409	£573,573	50%
16	Step down - extra care	Step down - extra care flats	Home Care or Domiciliary Care	Domiciliary care packages		7800	10920	Hours of care	Social Care		LA			Charity / Voluntary Sector	Local Authority Discharge	Existing	£504,775	£750,761	74%
17	Homecare capacity	Homecare capacity building	Home Care or Domiciliary Care	Domiciliary care packages		9360	18720	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge	New	£209,855	£485,000	3%
18	Nurse Assessor post	Post to assist with trusted assessor model	High Impact Change Model for Managing Transfer of Care	Trusted Assessment					Social Care		NHS			NHS Acute Provider	Local Authority Discharge	New	£39,698	£74,000	50%
19	Pathway development	Pathway development supporting effective discharges	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Local Authority Discharge	New	£31,156	£43,618	50%
20	Assistive technology	Provide telecare and assistive technology to all relevant pathway 0 and pathway 1	Assistive Technologies and Equipment	Assistive technologies including telecare		0	1111	Number of beneficiaries	Social Care		LA			Local Authority	Local Authority Discharge	New	£0	£40,000	100%
21	Step down beds - nursing	Step down beds - nursing	Residential Placements	Nursing home		10	10	Number of beds/Placements	Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£557,409	£573,573	50%
22	Workforce recruitment and retention	Supporting recruitment and retention - focus on homecare	Workforce recruitment and retention						Social Care		LA			Private Sector	Local Authority Discharge	New	£0	£271,203	84%
19	Pathway development	Pathway development supporting effective discharges	Enablers for Integration	Programme management					Social Care		LA			Local Authority	ICB Discharge Funding	New	£31,156	£43,618	50%
16	Step down - extra care	Step down - extra care flats	Home Care or Domiciliary Care	Domiciliary care packages		1700	0	Hours of care	Social Care		LA			Charity / Voluntary Sector	ICB Discharge Funding	Existing	£153,725	£0	26%
23	Low level voluntary sector support	Support for pathway 0 discharges	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess		300	1000		Social Care		LA			Charity / Voluntary Sector	ICB Discharge Funding	New	£35,000	£100,000	33%
26	Residential care contingency	Step down beds - residential	Residential Placements	Care home		0	28	Number of beds/Placements	Social Care		LA			Private Sector	ICB Discharge Funding	Existing	£0	£573,573	50%
27	Transport	NEAS contract for additional transport to support discharges	Other						Other	Ambulance Trust	NHS			NHS	ICB Discharge Funding	New	£86,366	£95,003	100%
22	Workforce recruitment and retention	Supporting recruitment and retention - focus on homecare	Workforce recruitment and retention						Social Care		LA			Private Sector	ICB Discharge Funding	New	£0	£53,499	16%
29	Disabled Facilities Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		55	55	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,869,024	£1,869,024	60%
30	Disabled Faculities Grant carry forward	Disabled Faculities Grant carry forward	DFG Related Schemes	Adaptations, including statutory DFG grants		37	0	Number of adaptations funded/people	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£1,257,308	£0	40%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: North Tyneside

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	272.8	280.7	307.7	266.0	Target was not achieved in 2022/23 (missed by 9% with an estimated outturn of 1139 compared to annual target of 1044) with continuing pressure experienced at emergency departments. Ambition set at 2022/23 estimated average outturn for the north end of the NENC region 1115, a 2% improvement on	Supported by the ongoing development of the frailty pathway and the integration of existing provision including mental health roles supporting the multi-disciplinary health and social care approach to delivery. Improvements relating to 2 hour urgent community response and the introduction of vuirtual ward approach for	Yes
	Number of Admissions	656	675	740	-			
	Population	205,985	205,985	205,985	205,985			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	282	246	303	284			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	3,213.8	3,171.0	3,171.0	There was an improvement between 2021/22 and 2022/23 despite residents presenting later with more complex needs. We have set the target as maintaining a standstill position in the light of our population showing increasing levels of frailty and are more prone to falling	Local falls service consisting of a falls pathway with specialist clinic, local exercise campaign and support, telecare service responding to falls including non injurous falls referred by ambulance service	Yes
	Count	1,360	1370	1370			Yes
	Population	43,213	43213	43213			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	88.1%	87.6%	87.6%	90.0%	Set a target of 90% as in 2022/23. We evaluate against an adjusted metric where those admitted to hospital from residential care and returning there are counted as being discharged to their normal place of residence. Our main trust does not code this way. We are concerned about continuing challenges in homecare capacity because of workforce issues.	Continued development of Carepoint within the integrated frailty service implementing the 'home first' response to hospital discharges. Measures to improve workforce issues in the local care market include paying a fee increase to support the Real Living wage and use of assistive technology solutions to increase the capacity of care in a person's own home.	Yes
	Numerator	4,496	4,605	4,676	4,550			
	Denominator	5,101	5,258	5,340	5,055			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	90.0%	90.0%	90.0%	90.0%			
	Numerator	4,590	4,770	4,860	4,860			Yes
	Denominator	5,100	5,300	5,400	5,400			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	497.1	402.3	802.3	762.7	National average rate in 2021/22 was 538.5 compared to North Tyneside's rate of 497.1. In 2022/23 we have experienced ongoing issues with homecare capacity leading to more use of residential care. In addition clients are more frail with higher	Additional extra care available from 2022/23 and are now largely filled (approx 100 units), measures to improve workforce issues in local homecare market (e.g. paying a fee increase to support the Real Living Wage) and use of short term	Yes
	Numerator	212	178	355	345			Yes
	Denominator	42,649	44,249	44,249	45,235			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.8%	90.0%	90.0%	85.0%	Performance dropped in 2022/23 as a result of higher level of deaths and admissions to residential care in line with generally higher level of frailty and comorbidities. Aim to return to improve level of performance to 85% in 2023/24	Careful management of skill mix within the service to maintain capacity - levels of experience and skill of staff vary due to recruitment issues and the age profile of staff. Restructuring of the service has taken place to deliver this target and to	Yes
	Numerator	167	180	180	170			Yes
	Denominator	184	200	200	200			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: North Tyneside

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes				Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

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