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North Tyneside Council

# Health and Wellbeing Board

3 November 2021

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

on **Thursday, 11 November 2021**

at **10.00 am**

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

**Agenda Item** **Page(s)**

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.

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.

Members of the public are welcome to attend this meeting and receive information about it.

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For further information about the meeting please call (0191) 643 5359.

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 16 September 2021.

5. **Joint Health & Wellbeing Strategy**
To approve a new Joint Health & Wellbeing Strategy focussed on addressing health inequalities.

(The Strategy document will be circulated separately in due course.)

6. **Carers**
To receive a presentation from Healthwatch North Tyneside and North Tyneside Carers Centre on the outcomes of consultation with carers.

7. **Better Care Fund Plan 2021/22** 11 - 38
To approve the North Tyneside Better Care Fund Plan 2021/22.

8. **Pharmaceutical Needs Assessment** 39 - 46
To agree a process for preparing a revised Pharmaceutical Needs Assessment.

**Members of the Health and Wellbeing Board:-**

Councillor Karen Clark (Chair)
Councillor Muriel Green (Deputy Chair)
Councillor Carole Burdis
Councillor Peter Earley
Councillor Joe Kirwin
Wendy Burke, Director of Public Health
Jacqui Old, Director of Children's and Adult Services
Richard Scott, North Tyneside NHS Clinical Commissioning Group
Lesley Young-Murphy, North Tyneside NHS Clinical Commissioning Group
Julia Charlton, Healthwatch North Tyneside
Paul Jones, Healthwatch North Tyneside
Christine Briggs, NHS England
Michael Graham, Newcastle Hospitals NHS Foundation Trust
Claire Riley, Northumbria Healthcare NHS Foundation Trust
Kedar Kale, Northumberland, Tyne & Wear NHS Foundation Trust
Susannah Thompson, TyneHealth
Craig Armstrong, North East Ambulance Service
Steven Thomas, Tyne & Wear Fire & Rescue Service
Claire Wheatley, Northumbria Police
Dawn McNally, Age UK North Tyneside
Vacancy, North Tyne Pharmaceutical Committee
Cheryl Gavin, Voluntary and Community Sector Chief Officer Group
Dean Titterton, YMCA North Tyneside

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# Health and Wellbeing Board

## Thursday, 16 September 2021

Present: Councillor K Clark (Chair)
Councillor P Earley
Councillor T Mulvenna
W Burke, Director of Public Health
R Scott, North Tyneside NHS Clinical Commissioning Group
J Charlton, Healthwatch North Tyneside
P Jones, Healthwatch North Tyneside
R Wigham, Northumbria Healthcare NHS Trust
A Oxley, Cumbria, Northumberland, Tyne & Wear NHS Trust
P Whelan-Moss, TyneHealth
Steven Thomas, Tyne & Wear Fire & Rescue Service
Claire Wheatley, Northumbria Police
S Robinson, Age UK North Tyneside
Cheryl Gavin, Voluntary and Community Sector Chief Officer Group
Dean Titterton, YMCA North Tyneside

In attendance: M Robson, M Taylor, S Woodhouse, L Gray, P Colby, C Woodcock and B Khazeali, North Tyneside Council

Apologies: Councillors C Burdis and M Green
J Old, Director of Children's and Adult Services
L Young-Murphy and A Paradis, North Tyneside NHS Clinical Commissioning Group
M Graham, Newcastle Hospitals NHS Trust
C Riley and N Contogiorgi, Northumbria Healthcare NHS Trust
K Kale, Cumbria, Northumberland, Tyne & Wear NHS Trust
S Thompson, TyneHealth
D McNally, Age UK North Tyneside

### HW1/21 Appointment of Substitute Members

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

Councillor T Mulvenna for Councillor M A Green
A Oxley for K Kale (Cumbria, Northumberland, Tyne and Wear Trust)
R Wigham for C Riley (Northumbria Healthcare Trust)
P Whelan-Moss for S Thompson (TyneHealth)
Sn Robinson for D McNally (Age UK North Tyneside)

### HW2/21 Declarations of Interest and Dispensations

Councillor K Clark declared a registerable personal interest in relation to the information provided by the People's Health Trust because she is an employee and Trustee of the Justice Prince Trust which has supported the work of the People's Health Trust in

Longbenton.

Councillor P Earley declared a registerable personal interest in relation to the report presented by Healthwatch North Tyneside because he is a Trustee of the North Tyneside Carers Centre.

**HW3/21 Minutes**

**Resolved** that the minutes of the previous meeting held on 8 July 2021 be confirmed and signed by the Chair subject to an acknowledgement that the proposed Office of Health Promotion was now to be called the Office of Health Improvement and Disparities.

**HW4/21 Joint Health & Wellbeing Strategy**

The Board received a comprehensive presentation on work being undertaken to develop a new Joint Health & Wellbeing Strategy focussed on addressing health inequalities.

The Board were presented with an analysis of what inequalities were. It was stated that inequalities were unfair and avoidable differences in socioeconomic circumstances across the population, and between different groups within society. They involved differences in health status, behavioural risks, wider determinants of health, access to care and quality and experience of care.

An officer working group had been established, under the direction of the Chair of the Board, to co-ordinate the work to develop a new Joint Health & Wellbeing Strategy.

As part of this work an impact analysis had been undertaken of the direct and indirect impacts of the Covid-19 pandemic. The Board were presented with the findings to emerge from this analysis. There had been multiple impacts on communities both direct from the burden of disease and mortality and the indirect effects of the response to the pandemic and the control measures that had been put in place. The Covid-19 pandemic and wider governmental and societal response had exacerbated some of health and wider inequalities already in existence at a national and local level. Due to their nature, these inequalities often overlapped and became more pronounced. Evidence suggested that those people who were least able to deal with the impact of the pandemic had been hit the hardest.

The Board were also presented with a summary of the evidence base which had been compiled for tackling inequalities. Particular reference was made to the ‘Marmot Approach’ proposed by the Institute of Health Equity and considered to be the most current, comprehensive and robust evidence base. The evidence indicated that inequalities arise because of the conditions in which we are born, grow, live, work and age. An inequalities strategy would need to take account of all of this, not just the visible consequences. A collaborative approach and action was needed across the whole of society and across the whole of the life course. It was suggested that the framework for a strategy should be in line with the Marmot approach and the six Marmot policy objectives with universal action that is at a scale and intensity, appropriate to the level of disadvantage and need.

Further work to profile current activity and approaches in the borough to tackle inequalities was underway and a consultation and engagement plan was in place, including use of the annual State of the Area Event in October. Once this work was complete a draft strategy

would be presented to the next meeting of the Health and Wellbeing Board in November.

The Board considered the plans to engage with hard to reach communities both during the development of the strategy and beyond when identifying the deliverables and formulating action plans.

In noting the startling impact of Covid-19 so far in North Tyneside, Board Members discussed the preparedness of local systems should a further wave of infections and restrictions occur. A number of key lessons had been learned throughout the past 18 months, particularly in relation to care homes and schools, and these lessons needed to be captured to ensure that the experience placed the system in a stronger position to deal with any future emergencies. Healthwatch North Tyneside had collated a lot of evidence relating to people's experiences of the pandemic which could help inform such an exercise. The Board acknowledged that much of the impact of Covid-19 was dependent on national policy and beyond local control.

The Board highlighted the long term challenges relating to housing and employment in tackling health inequalities and the limited interventions available to local authorities through the licensing and planning systems.

**Resolved** that the progress report on work to develop a new Joint Health & Wellbeing Strategy focussed on addressing health inequalities be noted.

## HW5/21 People's Health Trust

The Board was presented with details of the work undertaken by the People's Health Trust in relation to its resident-driven approaches to address the underlying causes of health inequalities. Member of the Board were invited to consider this information, and the approaches adopted by the People's Health Trust in addressing health inequalities, when developing the new Joint Health & Wellbeing Strategy.

## HW6/21 Healthwatch North Tyneside

The Board received a progress report from Healthwatch North Tyneside which provided an update on the activities of Healthwatch North Tyneside during the first half of 2021/22, highlighted the key pieces of work being undertaken and the feedback it had received during this period and described some of its activities for the coming months.

The Board were presented with copies of the Living Well booklet used to share important information with people receiving their Covid-19 vaccinations. The Living Well website was to be launched on 20 September 2021.

Healthwatch presented a summary of the feedback it had received from service users in relation to the Covid-19 vaccination programme, GP access and Livi, Menopause support, waiting for treatment, maternity and child health during Covid-19, pharmacy and prescriptions, carers experiences during Covid-19 and adult social care engagement.

It was suggested that the Board receive a more detailed report on the outcomes of consultation with carers carried out in conjunction with the North Tyneside Carers Centre and the North Tyneside Carers Partnership Board.

The Board acknowledged the efforts of staff at Healthwatch North Tyneside for what they had achieved working with the help and support of others in very difficult circumstances.

**Resolved** that (1) the work undertaken by Healthwatch North Tyneside be endorsed; and (2) the issues raised with Healthwatch by local residents be noted and be given due consideration within those relevant organisations represented on the Board.

## HW7/21 North Tyneside All Age Autism Strategy 2021-2026

The Board were presented with the North Tyneside Autism Strategy 2021-26. The strategy would move North Tyneside to a position that positively supported autistic people and their family members with an ultimate aim that North Tyneside was "autism friendly". The strategy was also to be presented to the North Tyneside Children's Board on 20 September 2021.

The strategy had been the result of working in partnership over the last two years to ensure that it was fully aligned to the requirements of local people but also was achievable and within the abilities of partner organisations that will deliver on the identified and agreed priorities. Autistic people and their families were to be at the heart of the strategy and its priorities. The following six priority areas contained in the strategy had come from people and family members.

- Being Listened to
- Awareness Raising
- Inclusive Communities
- Good Support
- Support through Life Changes
- Understanding yourself

Formulation of the strategy had coincided with the Government publishing an update to the National Autism Strategy in July 2021 and so the work in North Tyneside had been able to be aligned to and in keeping with the new national strategy. The six priority areas in the national strategy were:

- Helping people understand autism
- Helping autistic children and young people at school
- Helping autistic people find jobs and get the skills and training they need
- Making health and care services equal for autistic people
- Making sure autistic people get help in their communities
- Help autistic people in the justice system

The Learning Disability Integration Board would take the lead on the delivery of the strategy and the work plan to ensure the priority areas are developed and outcomes achieved. An Autism Delivery Working Group would be put in place to undertake this work, this group will largely be those individuals and organisations that were included in the development of the strategy.

**Resolved** that (1) the North Tyneside Autism Strategy 2021-2026, taking into account the National Autism Strategy priorities for 2021, be approved;
(2) the scope and work of the Learning Disability Integration Board be extended to include Autism and an Autism Strategy Steering Group be established to formulate and agree a detailed delivery plan;

(3) a timeframe for the Board receiving future updates and monitoring progress of the priorities be determined as part of formulation of the Board's work programme once the new Joint Health & Wellbeing Strategy has been agreed; and
(4) the priorities identified in the Autism Strategy be linked into and aligned with updated priorities from the upcoming refresh of the Joint Health and Wellbeing Strategy.

**HW8/21 Healthy Weight Declaration**

The Covid-19 pandemic had put the obesity epidemic once again into the spotlight by evidence of the link to an increased risk from Covid-19. Living with excess weight put people at greater risk of serious illness or death from Covid-19. Evidence suggested that whilst more people had exercised during lockdown, the nation's exercise levels had not increased overall and snack food and alcohol sales had increased substantially. In response the Government had launched a new obesity strategy in July 2020 the Better Health campaign.

Tackling obesity was one of the greatest long-term health challenges and one of the most important factors in improving the health of the population. Obesity is the result of complex relationships between genetic, socioeconomic, and cultural influences and as a result requires a whole systems approach, across the lifecourse to address the root causes. The Board had previously established a Healthy Weight Alliance to bring together partners to develop a plan to address obesity at a population level across the borough.

The Local Authority Declaration on Healthy Weight had been developed by Food Active, a charitable organisation established to support organizations and their partners to take action to prevent excess weight and secure the health and wellbeing of the population. The Declaration was a strategic, system-wide commitment to tackling excess weight and physical inactivity. It was suggested that it could provide an effective platform and framework to deliver the Health Weight Alliance's plan.

The declaration comprised 16 standard commitments which were designed to be bold but achievable, with the opportunity for areas to make further local commitments to supplement the declaration if they wish. The 16 commitments are grouped under the following headings:

- Strategic / System Leadership
- Commercial Determinants
- Health Promoting Infrastructure / Environments
- Organisational Change / Culture Shift
- Monitoring & Evaluation

A Healthy Weight Alliance workshop had been held on the 27 July 2021 with partners across the system led by the public health team and chaired by the Councillor Karen Clark, setting out the context and challenges of tackling obesity in North Tyneside and outlining the benefits of adopting the Declaration. The proposal to adopt the Declaration was well received by partners and gained overwhelming support. In addition, Northumbria Healthcare Trust (NHCT) also expressed an interest in adopting the Declaration, which would support their work as an Active Hospital. The intention was to aim for a joint launch event with the Trust in January 2022.

The Board considered how the Declaration could complement the Better Health Work Award and North Tyneside CCG's How Fit campaign.

**Resolved** that (1) the Board take a lead role, through the work of the Healthy Weight Alliance, in ensuring there is a whole systems approach to preventing excess weight by addressing both the obesogenic environment in which we all live, as well as supporting individuals; and
(2) the Board encourages and supports North Tyneside Council and Northumbria Healthcare NHS Trust to adopt the Healthy Weight Declaration and achieve its 16 commitments; and
(3) the Board continues to oversee the delivery of the Healthy Weight Alliance's plan to address obesity at a population level across the borough.

# North Tyneside
# Health & Wellbeing Board Report
# Date: 11 November 2021

**Title: Better Care Fund Plan for 2021/22**

**Report from:** North Tyneside Council & North Tyneside CCG

**Report Author:** Kevin Allan, Programme Manager, Integrated Care for Older People (Tel: 0191 643 6078)

## 1. Purpose:

This report presents a proposed plan for the Better Care Fund (BCF) covering the financial year 2021/22.

## 2. Recommendation(s):

The Board is recommended to

a) approve the attached Better Care Fund Plan, and

b) authorise the Director of Services for Children and 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 16th November 2021.

## 3. Policy Framework

This item relates to the following objectives of the Joint Health and Wellbeing Strategy 2013-23:

- To continually seek and develop new ways to improve the health and wellbeing of the population
- To shift investment to focus on evidence based prevention and early intervention where possible
- To reduce the difference in life expectancy and healthy life expectancy between the most affluent and most deprived areas of the borough;
- To shift investment to focus on evidence based prevention and early intervention;
- To build resilience in local communities through focussed interventions and
- ownership of local initiatives to improve health and wellbeing; and
- To integrate services where there is an opportunity for better outcomes for the public and better use of public money

## 4. Information:

The BCF Policy Framework for 2021-22[1] was published on 19th August 2021 by the Department of Health and Social Care and the Department for Levelling Up, Housing, and Communities. It was supplemented by the BCF Planning Guidance published on 1st October 2021.

The Framework notes:

> "The government is committed to person-centred integrated care, with health, social care, housing and other public services working together to provide better joined up care. Enabling people to live healthy, fulfilled, independent and longer lives will require these services to work ever more closely together towards common aims. The response to the coronavirus (COVID-19) pandemic appears to have accelerated the pace of collaboration across many systems and the government is keen to maintain momentum and build upon positive changes.
>
> The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires clinical commissioning groups (CCGs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).
>
> The response to the COVID-19 pandemic has demonstrated how joint approaches to the wellbeing of people, between health, social care and the wider public sector can be effective even in the most difficult circumstances.
>
> Given the ongoing pressures in systems, there will be minimal change to the BCF in 2021 to 2022. The 2021 to 2022 Better Care Fund policy framework aims to build on progress during the COVID-19 pandemic, strengthening the integration of commissioning and delivery of services and delivering person-centred care, as well as continuing to support system recovery from the pandemic."

In 2020/21, there was no requirement to submit a formal BCF Plan to government, due to the pressures related to COVID-19. This year, the requirement for a plan has been reintroduced. The plan will be reviewed by a regional panel before approval by the national bodies[2]

2021-22, the Framework states, is to be a year of minimal change for the BCF:

- BCF plans should be signed off by Health and Wellbeing Boards
- CCGs will continue to be required to pool a mandated minimum amount of funding
- Local Authorities will be required to pool grant funding from the Improved Better Care Fund and the Disabled Facilities Grant.
- The Improved Better Care Fund, as in previous years, can be used only to meet adult social care needs; reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and to ensure that the local social care provider market is supported.

[2] The relevant national bodies are the Department of Health and Social Care, Department of Levelling Up, Housing, and Communities, NHS England, and the Local Government Association.

There are, however, changes to the National Conditions against which plans will be assessed.

**National conditions**
Three national conditions are unchanged:

1. A jointly agreed plan between local health and social care commissioners, signed off by the HWB;
2. NHS contribution to adult social care to be maintained in line with the uplift to the CCG minimum contribution
3. Invest in NHS-commissioned out-of-hospital services

There is one new national condition:

4. A plan for improving outcomes for people being discharged from hospital

**Metrics**
The Policy Framework mandates amended metrics to support the updated national conditions.

1. Effectiveness of reablement (as in previous years)
2. Permanent admissions of older people to residential care (as in previous years)
3. Unplanned hospitalisations due to chronic ambulatory care sensitive conditions (replaces a previous metric of all emergency hospital admissions)
4. Hospital discharge metrics. These are new metrics, replacing a previous measure of Delayed Transfers of Care, and consisting of:
    a) Percentage of patients discharged from hospital who had a length of stay of 14 days or more;
    b) Percentage of patients discharged from hospital who had a length of stay of 21 days or more;
    c) Percentage of patients discharged from hospital who were discharged to their normal place of residence

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.

**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 NHS North Tyneside Clinical Commissioning Group (CCG). 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 Clinical Commissioning Group, 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 CCG will also be asked to agree the BCF Plan.

## The value of the Better Care Fund

The minimum value of the North Tyneside Better Care Fund is set nationally.

**Table 1**

| Income Component | 2018/19 | 2019/20 | 2020/21 | 2021/22 | % change this year |
|---|---|---|---|---|---|
| Disabled Facilities Grant | 1,526,533 | 1,647,220 | 1,647,220 | 1,869,024 | 13.5% |
| Minimum CCG Contribution | 15,833,838 | 16,603,777 | 17,420,966 | 18,291,187 | 5.0% |
| Improved Better Care Fund | 6,772,688 | 8,265,809 | 9,296,886 | 9,296,886 | 0.0% |
| Winter Pressures Grant | 0 | 1,031,077 | 0 | 0 | |
| TOTAL | 24,133,059 | 27,547,883 | 28,365,072 | 29,457,097 | 3.8% |

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

**Table 2**

| | 2018/19 | 2019/20 | 2020/21 | 2021/22 | % change this year |
|---|---|---|---|---|---|
| CCG minimum contribution to adult social care | 10,085,863 | 10,576,301 | 11,096,836 | 11,651,150 | 5.0% |
| NHS commissioned out-of-hospital spend | 4,449,528 | 4,718,332 | 4,950,544 | 5,197,836 | 5.0% |

## Key features of the BCF plan

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 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; and seven day social work.
- Intermediate Care beds, including bed-based facilities complemented by a community rehabilitation team
- Enhanced primary care in care homes
- A hospice-at-home service for end of life care
- A community falls first responder service

- Liaison Psychiatry for working-age adults
- Support for people with learning disabilities
- 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, including meeting the costs of paying the Living Wage to staff in care homes and home care. These investments also support hospital capacity by helping to ensure that discharge services are sufficient to meet demand.

The Disabled Facilities Grant 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 well being; maintain family stability; improve social inclusion ; and enhance employment opportunities of the disabled person.

This plan provides continuity with the previous BCF plan. The COVID-19 pandemic has accelerated the provision of hospital discharge services based on a “home-first” approach, which was already under way. Our priorities for 2021/22 and beyond are to regain progress in the establishment of the integrated frailty service, which was impacted by the pandemic, and to maintain admission avoidance and hospital discharge services, thus supporting hospital capacity.

The CCG and Local Authority will continue to review the specifications to ensure that the BCF funds are spent in the best way to meet population needs, in a way that provides value for money.

## 5. Decision options:

The Board may either:-

a) approve the attached Better Care Fund Plan, set out in the report; and
b) 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 16th November 2021.

or

c) 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 option a). The continuation of the Better Care Fund presents a major opportunity to take forward the principles of the 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 A - North Tyneside BCF Plan 2021/22

## COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

### 8. Financial Implications

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

### 9. Legal Implications

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 clinical commissioning group.

### 10. Equalities and diversity

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

### 11. Risk management

A risk assessment has been undertaken and included in Appendix A

### 12. 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 |
| Director of Children's and Adult Services | X |
| Director of Healthwatch North Tyneside | X |
| CCG Chief Officer | X |
| Director of Resources | |
| Director of Law & Governance | X |

# North Tyneside Health and Wellbeing Board

# Better Care Fund Plan 2021-2022

## 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 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; and seven day social work.
- Intermediate Care beds, including bed-based facilities complemented by a community rehabilitation team
- Enhanced primary care in care homes
- A hospice-at-home service for end of life care
- A community falls first responder service
- Liaison Psychiatry for working-age adults
- Support for people with learning disabilities
- Implementation of the Care Act, support for carers, and the provision of advice and information.

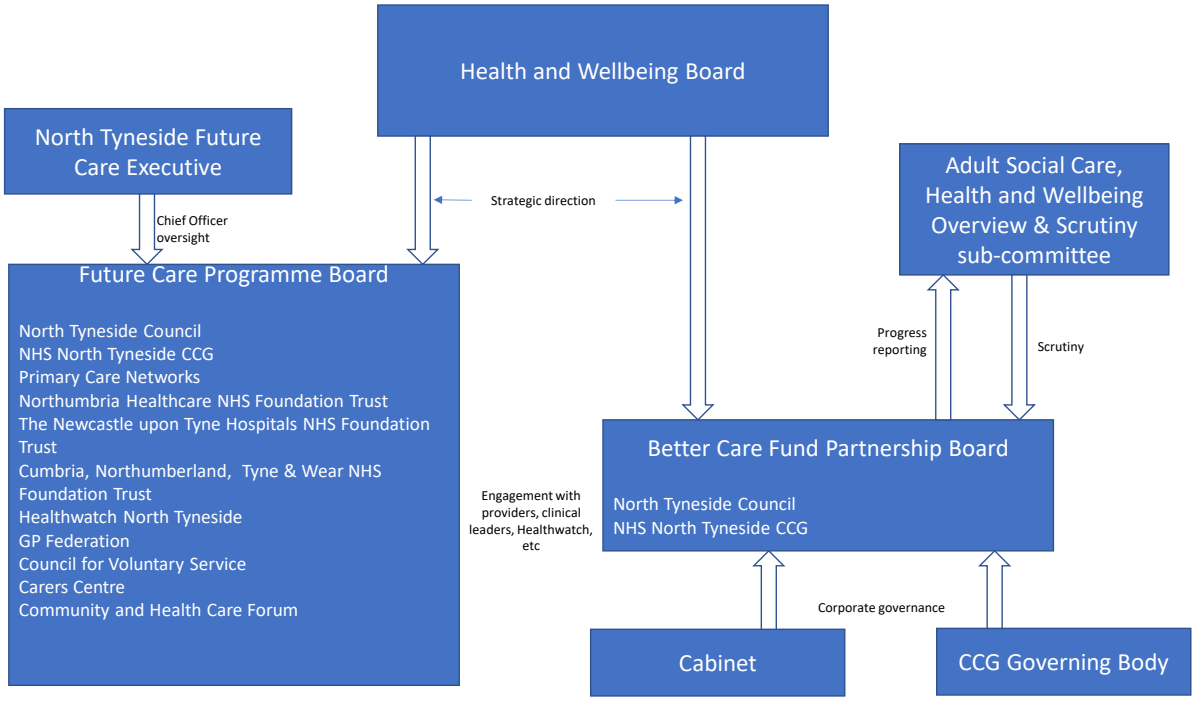
The Improved Better Care Fund element will be used to support the social care market, including meeting the costs of paying the Living Wage to staff in care homes and home care. These investments also support hospital capacity by helping to ensure that discharge services are sufficient to meet demand.

The Disabled Facilities Grant will be used to enable people to live independently in their own home; minimise risk of injury for customer and carer ; revent 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 ; and enhance employment opportunities of the disabled person.

This plan provides continuity with the previous BCF plan. The COVID-19 pandemic has accelerated the provision of hospital discharge services based on a “home-first” approach, which was already under way. Our priorities for 2021/22 and beyond are to regain progress in the establishment of the integrated frailty service, which was impacted by the pandemic, and to maintain admission avoidance and hospital discharge services, thus supporting hospital capacity.

# Governance

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 Future Care Programme Board is our place-based planning mechanism which brings together stakeholders to define and implement a strategy to deliver a patient-centred sustainable health and social care system. It is supported by sub-groups including the Ageing Well Board, which is responsible for the design and delivery of the Ageing Well strategy, including development of an integrated frailty service, end of life care, mental wellbeing in later life, and falls services.

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 CCG 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.

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

## 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
- Reduction in bed-based care.
- Right Care, Right Place and Right Time
- North Tyneside system is seen as a preferred place to work with high levels of wellbeing, satisfaction, recruitment and retention.

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.

The Local Authority and the Clinical Commissioning Group 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. More so, over the last 18 months we have seen increasing need for collaboration, joint working and integrated services to meet the health and social care needs of the borough.

The Better Care Fund is a vehicle to support that integrated work to ensure that funding put in place in social care services is also targeted at freeing up health services and ensuring there is a good flow of people either out of hospital or preventing admission in the first place. Some specific examples of this would include:

- The Local Authority leads 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

- The Local Authority is commissioned by the CCG to undertake continuing health care case management work and to commission CHC placements and packages in the community agreed by the CCG
- 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 work undertaken within the Frailty Pathway Group will deliver on a new Integrated Frailty Service for the borough with integrated provision and services

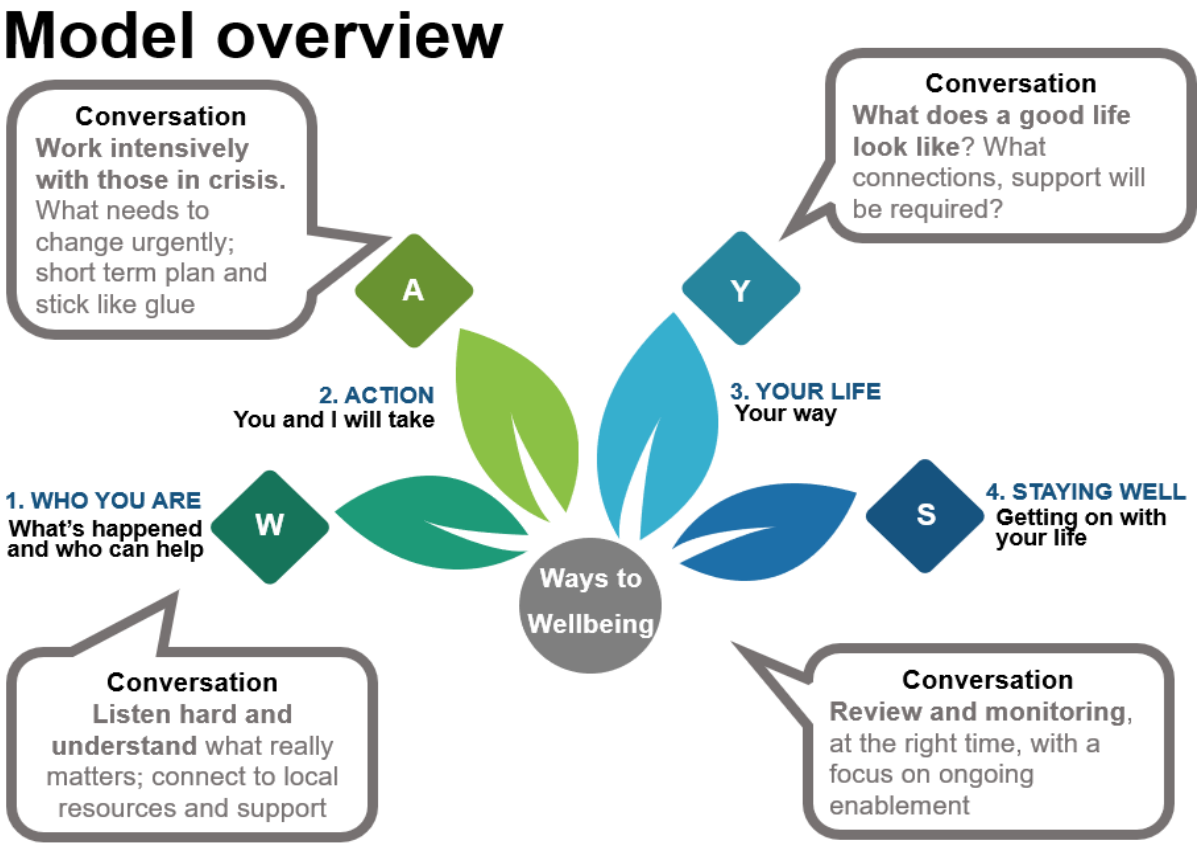
Our use of a strengths-based approach and person-centred care is shown by the development of the “Ways to Wellbeing” model within adult social care. This provides a practice model which

- 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

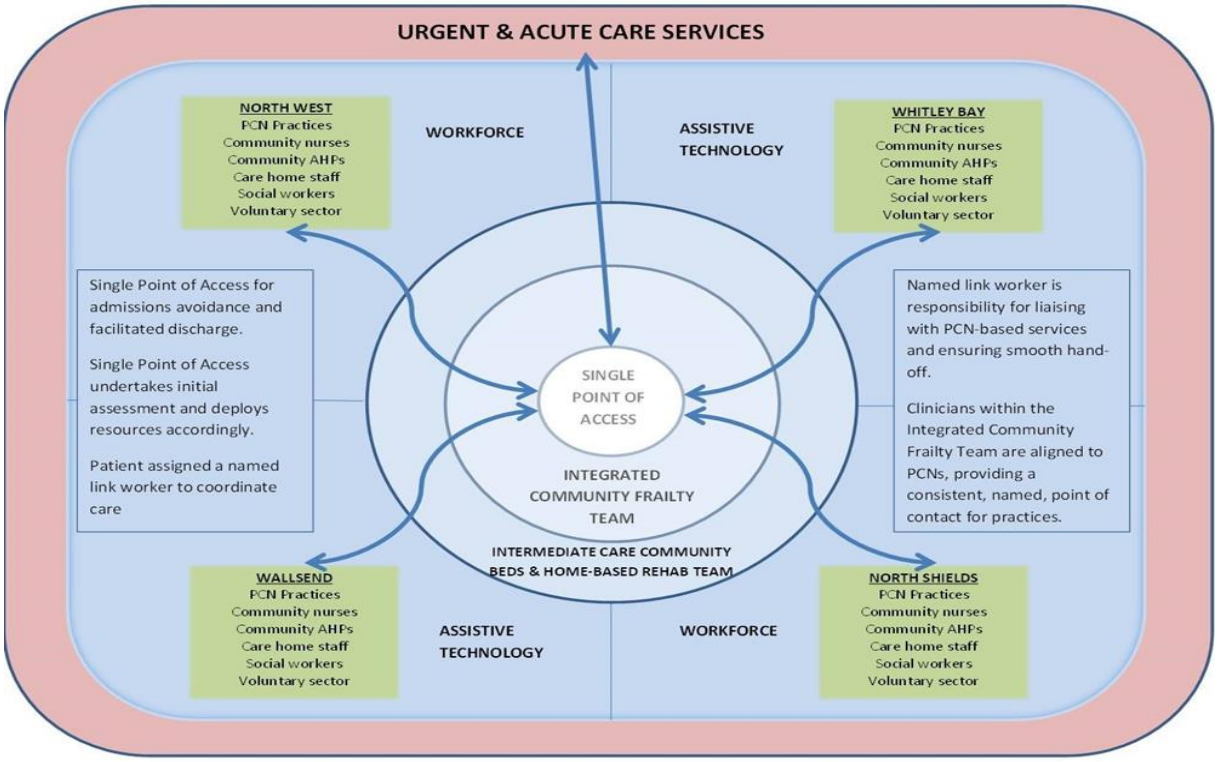
*Figure 1: The "ways to wellbeing" practice model*




## 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 the intermediate care beds at Howden and Royal Quays.

- The development of an integrated frailty service within exiting NHS and Local Authority services contracts.
- The development of a new community bed based intermediate care facility at Backworth, 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 frailty elderly patients. It is expected that, subject to planning permission and procurement processes, building will commence in Q1, and complete in Q4, of 2022.
- A cohort of 17 Community Care Practitioners have been recruited to work in the service and will complete a university programme in April 2022.




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
- Falls First Responder
- 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 c.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 SPA.

- 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.

*Enhanced Health Care in Care Homes* provides a proactive service to improve the planning, delivery, and quality of care for care home residents.

*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.

The *Community Falls First Responder Service* provides a first response for patients who contact the ambulance service via 111/999 having fallen.

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.

**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 service adopts a “home first” process, which has accelerated and intensified during the COVID-19 period.

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.
- *Enhanced Health Care in Care Homes* helps to support patients who are discharged to a care home, including avoiding re-admission.

# Disabled Facilities Grant (DFG)

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 agreed a new policy on the use of the Disabled Facilities Grant in March 2018, in line with the Regulatory Reform Order 2002. The revised policy contained the following significant changes:

- Any adaptation that costs less than £10,000 will not involve a means test. This represents value for the tax payer as it means that adaptations can 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 old ceiling was ruling out Grants in circumstances which would otherwise represent value for money.
- 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. Particular attention will also be paid to high cost care packages.
- 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

The services funded through the BCF are accessed and delivered without reference to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Patients in older age groups, and with a disability, are more likely than average to be users of health and care services; this is appropriate to their needs.

With respect to hospital discharge metrics, Figure **Error! Reference source not found.** below shows that patients from an ethnic minority are less likely than white patients to have a length of stay in hospital over 14 days. 6% of ethnic minority patients experienced a hospital stay of 14 days or more, compared to 10.1% of white patients.

*Figure 2: Percentage of hospital patients with Length of Stay 21+ days, by ethnic origin. Source: Secondary Uses Service data*

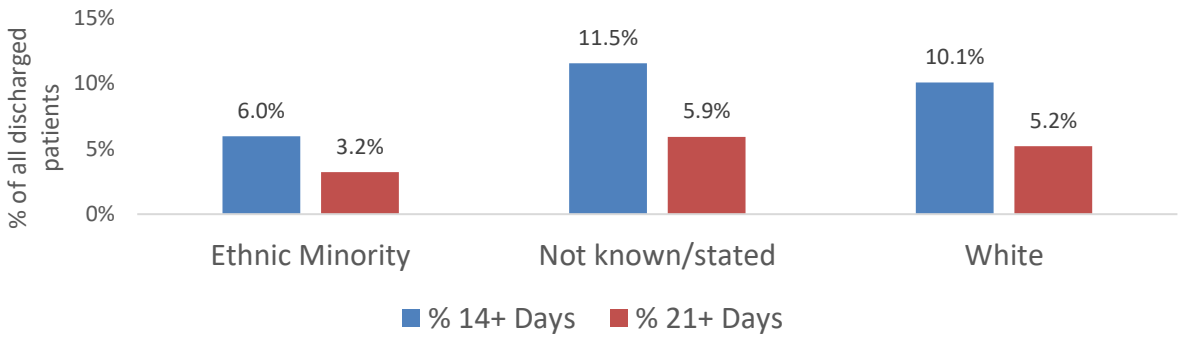
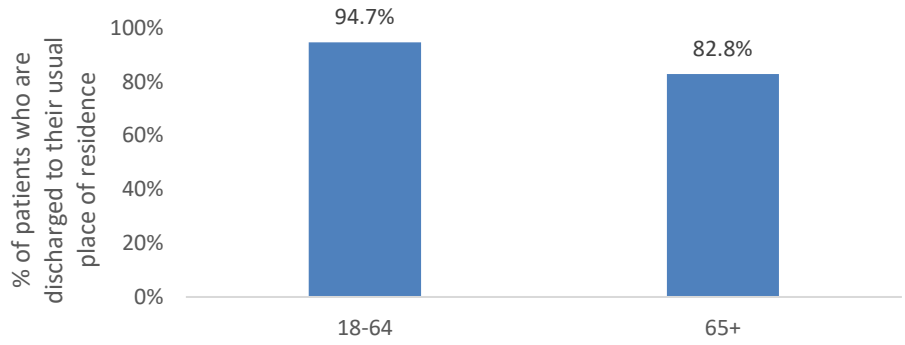



Figure 3 below shows that ethnic minority patients are very slightly less likely than white patients to be discharged from hospital to their usual place of residence.

*Figure 3: Percentage of hospital patients who are discharged to their usual place of residence, by ethnic origin. Source: NHS Digital BCF Data Pack v2*

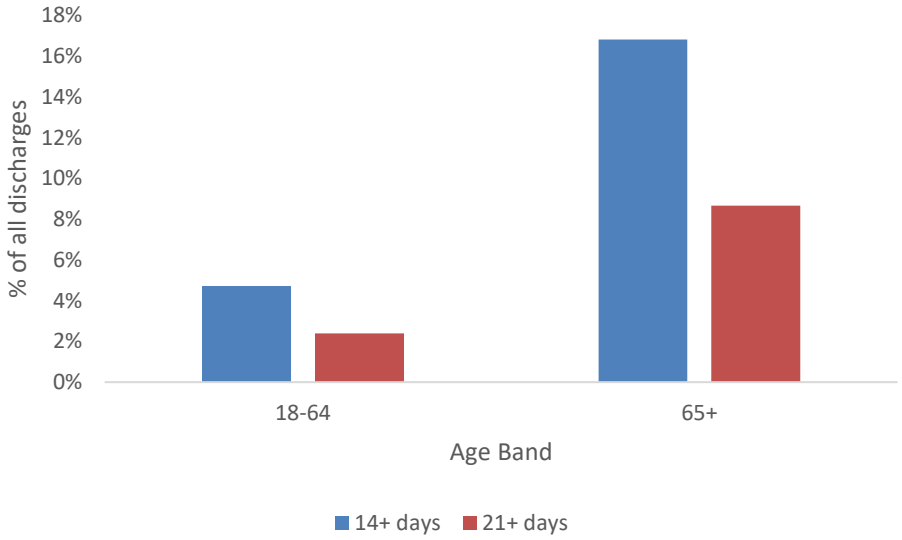

Figure 4 shows that the probability of being discharged to usual place of residence declines with age. The majority of our BCF services are focused on older people in response to the growing levels of need in the older age groups.

*Figure 4: Percentage of hospital patients discharged to their usual place of residence. by age bands. Source: Secondary Uses Service*




This trend is also shown in Figure 5; the probability of having a hospital length of stay of 21+ days increases with age.

*Figure 5: Percentage of hospital patients with a length of stay of 14+ or 21+ days, by age bands. Source: Secondary Uses Service*



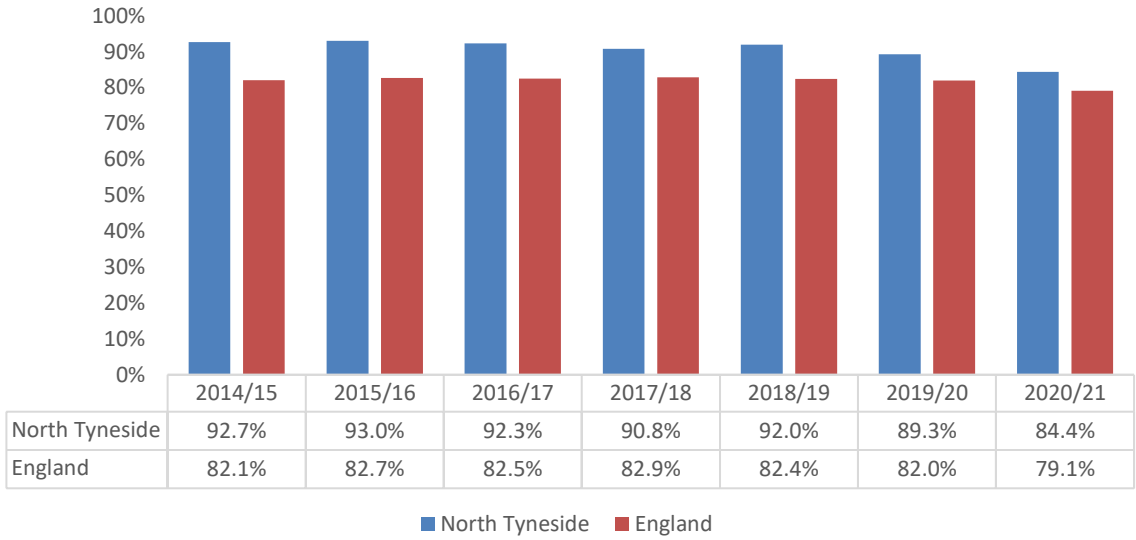
# Appendix 1 - BCF Metrics

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. We expect to maintain performance at 85% in 2021/22.

*Figure 6: Effectiveness of reablement metric, time series*

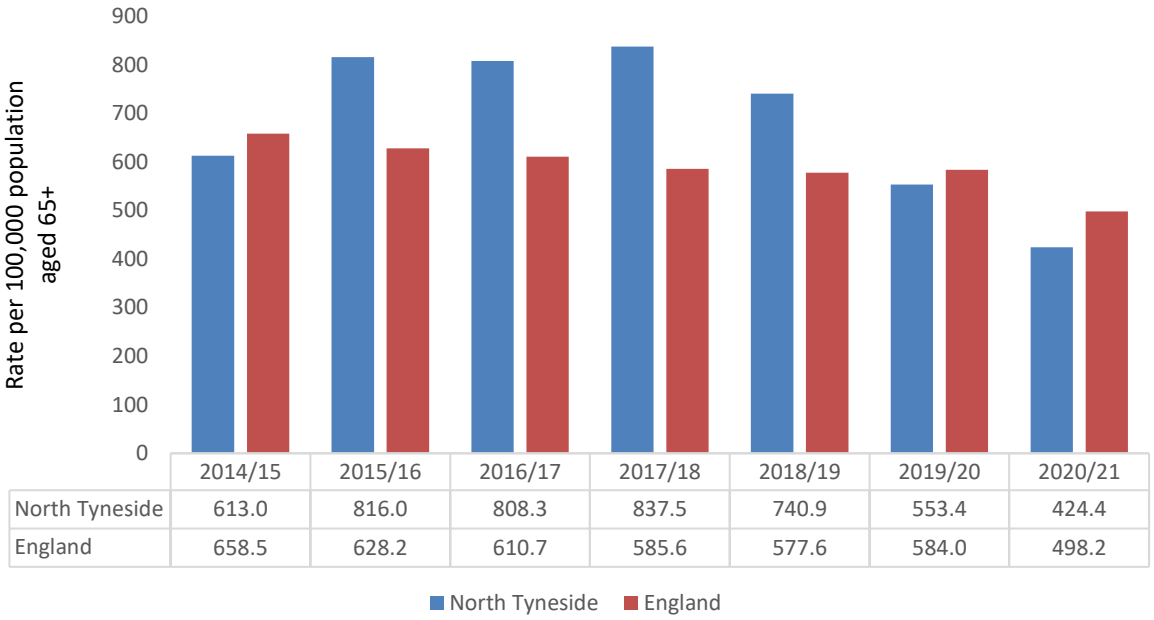



| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|---|---|
| North Tyneside | 92.7% | 93.0% | 92.3% | 90.8% | 92.0% | 89.3% | 84.4% |
| England | 82.1% | 82.7% | 82.5% | 82.9% | 82.4% | 82.0% | 79.1% |

*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 two financial years. In 2020/21, expect the outturn was influenced by the COVID-19 pandemic, 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.

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




| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|---|---|
| North Tyneside | 613.0 | 816.0 | 808.3 | 837.5 | 740.9 | 553.4 | 424.4 |
| England | 658.5 | 628.2 | 610.7 | 585.6 | 577.6 | 584.0 | 498.2 |

For 2021/22 we expect the outturn to be 612 admissions per 100,000 people aged 65+.

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.

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

- We currently have nine extra care schemes across North Tyneside with 375 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.

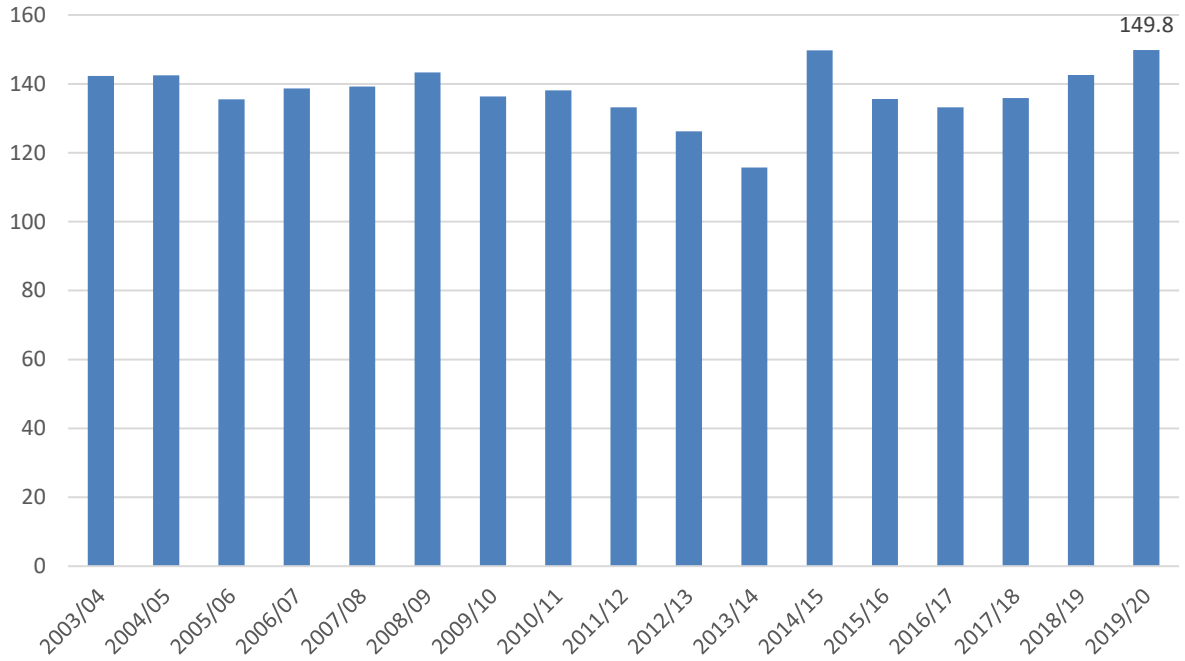
- There are plans for a further two extra care schemes with 104 apartments to come on stream by 31 March 2022. One of these schemes with 40 beds will be dementia specific and will offer a real alternative to a placement in a care home.

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 a standardised ratio where the England rate = 100. For example, in 2019/20 the North Tyneside rate was almost

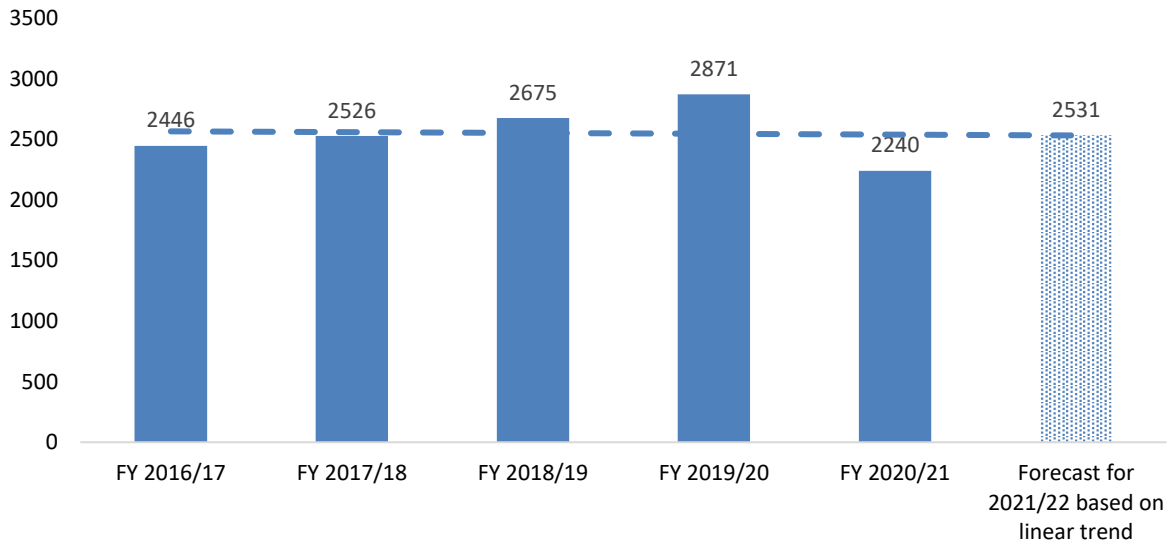
50% higher than the England rate, after taking into account any differences in the age structure of the population.

*Figure 8: Standardised ratio of chronic ambulatory care sensitive conditions*




The data for 2020/21 will not be published on an HWB basis until February 2022; an estimate for North Tyneside CCG is shown in Figure 8 below.

*Figure 9: Time series and forecast of unplanned hospital admissions for chronic ambulatory care conditions*




The overall reduction in the number of hospital admissions due to COVID in 2020/21 led to a reduction in this metric; we expect that the outturn for 2021/22 will be greater than 2020/21 (as recovery from COVID takes place) but lower than the two years

before, on the basis of a general reducing trend as illustrated by the dashed line in Figure 9.

Our ambition for 2021/22 is 2531 unplanned admissions[1]

BCF services will impact this goal by:

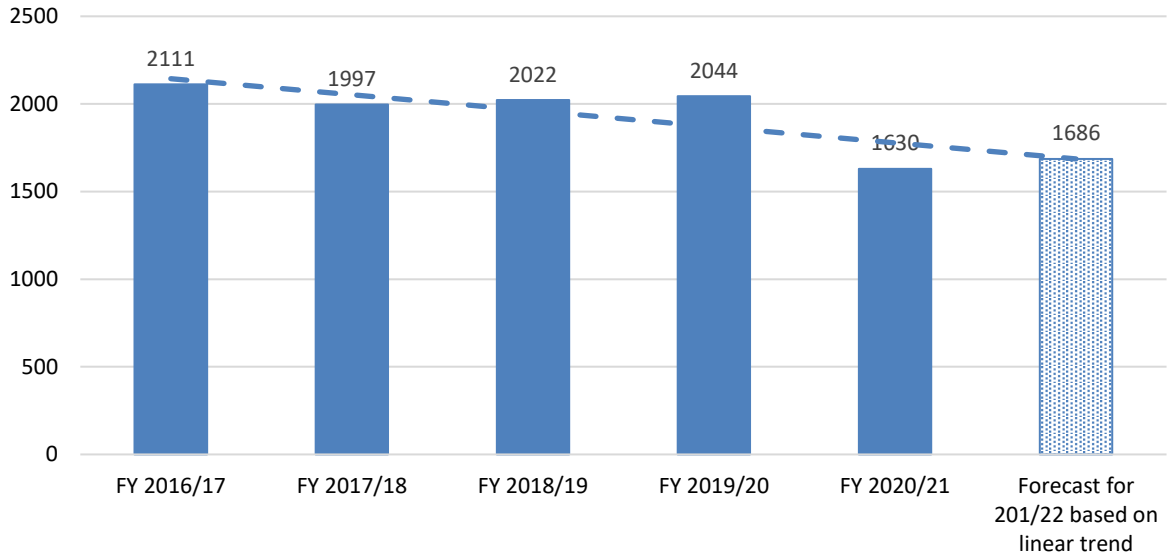
- The Enhanced Care in Care Homes service improves the planning and delivery of healthcare for care home residents, maintains and enhances the quality of care, and increases the number of healthcare interventions that are carried out in a care home setting, hence reducing the number of unplanned admissions 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.
- The provision of high quality discharge planning by CarePoint (an element of the Ageing Well service) reduces the probability of readmission following a sub-obtimal 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 being put 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.
- The method of recording Same Day Emergency Care is not standardised across the country, so some Trusts record these cases as inpatients, and some as outpatients. When SDEC are excluded from SUS data, the number of true admissions related to chronic ambulatory care sensitive conditions is shown to be lower than suggested by national data (see Figure 10)

[1] It is not possible to calculate a standardised ratio as requested by the national BCF planning template, as the methodology to do so requires access to the data for all other HWBs, which we do not have.

*Figure 10: Time-series and forecast of unplanned admissions for chronic ambulatory care sensitive conditions, with Same Day Emergency Care excluded*




*4 Percentage of patients who have been an inpatient in the acute hospital for:*

*i) 14 days or more*
*ii) 21 days or more*

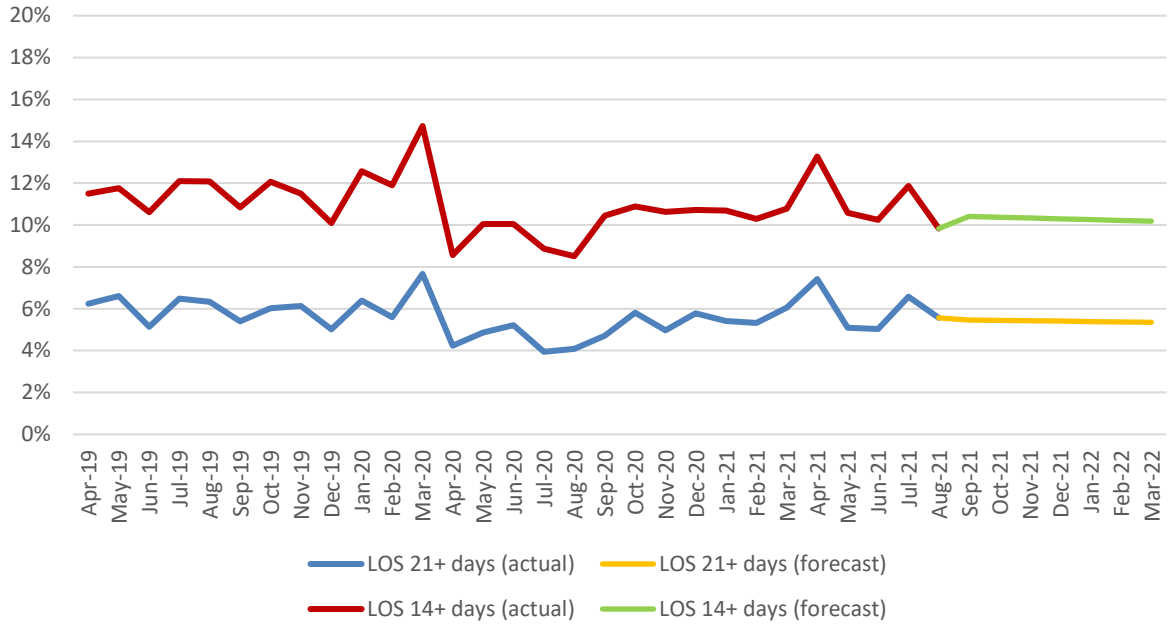
*As a percentage of all inpatients*

Figure 11 below shows that there has been a declining trend in the proportion of patients in hospital for both 14+ days and 21+ days.

The North Tyneside average for the period April 2019-March 2021 was the same as the English average for 14+ days (10.9%) whilst the North Tyneside average for 21+ days (5.6%) was below the English average (5.8%).

We expect the outcome for 2021/22 to be 10.6% of patients being in hospital for more than 14 days, and 5.6% to be in hospital more than 21 days.

*Figure 11:Time series and forecast of discharged patients with LOS of 14+ days and 21+ days*




BCF services will impact this goal by:

- Enhancing intermediate care bed-based services to ensure they are available for "step-up" care to avoid hospital admission as well as expediting discharges.
- The Enhanced Healthcare in Care Homes service will create greater confidence in the ability to discharge care home residents, with appropriate high-quality medical support available in the care home.

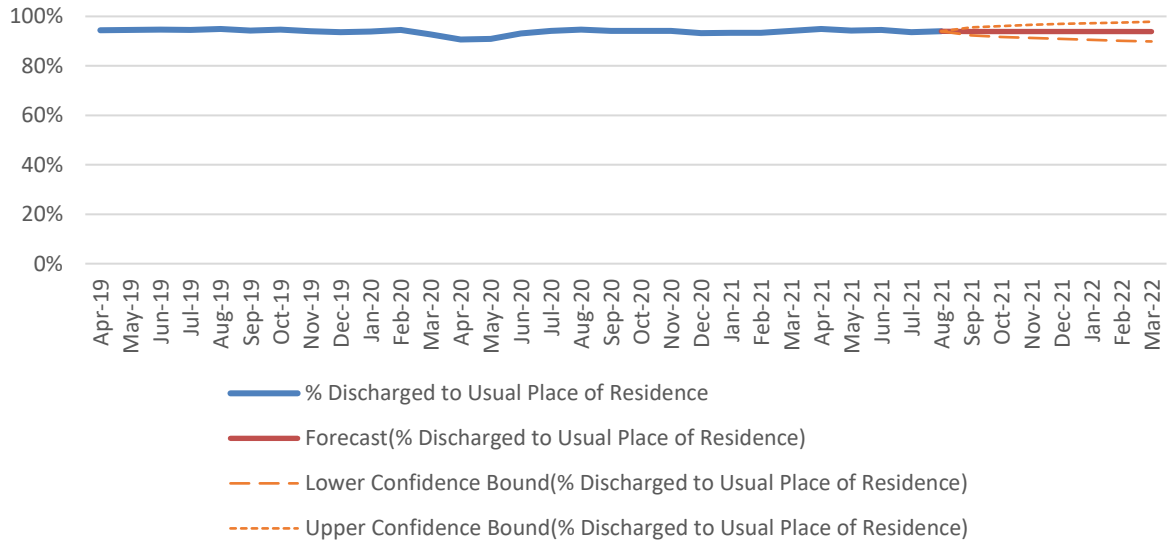
Other developments, not part of the BCF scope, will impact as follows:

- Providers will continue to implement best practice as set out in NHS England/NHS Improvement guidance for example:
    - Work at the front door, including Same Day Emergency Care, therapy services, and appropriate care pathways to avoid admissions for patients who do not require acute care in hospital and are at risk of deconditioning if they do.
    - Routinely screening within 2 hours of presentation all older people for their prior degree of frailty using a validated tool, their prior level of functional need, and their present cognitive status.
    - Proactively planning for discharge home of those patients who most vulnerable to hospital-associated deconditioning and who are judged fit enough to be provided rehabilitation and recovery care in a community setting.
    - Work to address bottlenecks, including by implementing Red2Green and SAFER patient flow bundle

5 Percentage of people who are discharged from acute hospital to their normal place of residence.

Figure 12 below shows the proportion of people discharged to their normal place of residence from April 2019 to July 2021. The rate for North Tyneside was lower than the England average throughout the period, except for one month,

*Figure 12: time-series and forecast of % of people who are discharged from hospital to their normal place of residence*




We expect the outcome for 2021/22 to be 94.0%

BCF services will impact this goal by:

- 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, and the use of the Disabled Facilities Grant, which helps people to maintain their independence at home.

# 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; and seven-day social work | Social Care | Minimum CCG Contribution | 8,478,578 |
| 27 | Community-based support | Health contribution to CarePoint | Community Health | Minimum CCG Contribution | 1,586,470 |
| 2 | Intermediate Care beds | Intermediate Care | Community Health | Minimum CCG Contribution | 2,984,418 |
| 3 | Intermediate Care - Community Services | Community Rehabilitation Team | Social Care | Minimum CCG Contribution | 863,000 |
| 4 | Liaison Psychiatry - Working Age Adults | Liaison Psychiatry - Working Age Adults | Mental Health | Minimum CCG Contribution | 786,361 |
| 6 | Enhanced Primary Care in Care Homes | Enhanced Primary Care in Care Homes | Primary Care | Minimum CCG Contribution | 1,032,301 |
| 19 | End of Life Care - RAPID | End of Life Care | Community Health | Minimum CCG Contribution | 250,488 |
| 8 | Improving access to advice and information | MyCare and Living Well in North Tyneside digital services | Social Care | Minimum CCG Contribution | 36,148 |
| 9 | Care Act implementation | Care Act implementation | Social Care | Minimum CCG Contribution | 739,097 |
| 10 | Carers Support | Carers Support | Social Care | Minimum CCG Contribution | 671,000 |
| 12 | Independent Support for People with Learning Disabilities | Independent Support for People with Learning Disabilities | Social Care | Minimum CCG Contribution | 718,928 |
| 25 | Community Falls First Responder Service | Avoiding unnecessary paramedic response to falls at home | Social Care | Minimum CCG Contribution | 144,399 |

| Scheme ID | Scheme Name | Brief Description of Scheme | Area of Spend | Source of Funding | Expenditure (£) |
|---|---|---|---|---|---|
| 13 | Impact on care home fees of national living wage | Meet costs of paying living wage to staff in care homes | Social Care | iBCF | 2,638,468 |
| 14 | Impact on domicilliary care fees of national living wage | Meet costs of paying living wage to staff of home care providers | Social Care | iBCF | 839,584 |
| 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 | 3,918,400 |
| 16 | Effect of demographic growth and change in severity of need | Increased volume and complexity of social care provision | Social Care | iBCF | 1,900,434 |
| 26 | Disabled Facilities Grant | Disabled Facilities Grant | Social Care | DFG | 1,869,024 |
| TOTAL | | | | | 29,457,097 |

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# North Tyneside Health & Wellbeing Board Report Date: 11 November 2021

**Title: Pharmaceutical Needs Assessment**


| | | |
|---|---|---|
| **Report from:** | North Tyneside Council | |
| **Responsible officer:** | Wendy Burke, Director of Public Health<br>Lesley Young Murphy Chief Operating Officer North Tyneside CCG | (0191) 643 8073 |
| **Report authors:** | Rachel Nicholson, Senior Public Health Manager, NTC<br>Steve Rundle, Head of Planning and Commissioning, NTCCG<br>Suzy Cooke, Public Health Specialty Registrar, NTC | |


## 1. Purpose:

The purpose of the report is to identify and agree the process for the Health and Wellbeing Board to publish an updated Pharmaceutical Needs Assessment (PNA) by 1 October 2022 in line with the statutory requirements.

## 2. Recommendation(s):

The Board is recommended to:

a) Agree the process for reviewing, updating and publishing the PNA for the deadline of 1st October 2022 as set out in the implementation plan.
b) Agree the membership of the steering group.

## 3. Policy Framework

There is a statutory duty under the Health and Social Care Act 2012 for Health and Wellbeing Boards to undertake a PNA. On 1st April 2013, Health and Wellbeing Boards of every local authority in England were required to develop a PNA for the first time and ensure that it was published by 1st April 2015. The PNA must be reviewed every 3 years. The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 sets out the legislative basis for developing the PNAs.

The last PNA was published in North Tyneside on 1st April 2018. PNAs must be completely reviewed at least every three years and was therefore due to be renewed and published no later than 1 April 2021. However, the Department of Health and Social care (DHSC) announced on 21 May 2020 a suspension of publishing PNAs, from April 2021 until April 2022 due to the COVID-19 pandemic. A further 6 month extension was then granted by DHSC to 1st October 2022.

The development of a PNA is a separate duty to that of developing a Joint Strategic Needs Assessment. PNAs inform commissioning decisions by local authorities, NHS England and by Clinical Commissioning Groups (CCGs).

## 4. Information:

The purpose of a PNA is:

- To determine if there are enough community pharmacies to meet the needs of the population of North Tyneside. NHS England uses the PNA to determine applications to open new pharmacies in the Local Authority area.
- To act as a guide for commissioners to determine services which could be delivered by community pharmacies to meet the identified health needs of the population.

An implementation plan has been developed to review and update the PNA, including a plan for consultation in line with statutory guidance and in advance of the Health and Wellbeing Board agreeing the final version to be published by 1st October 2022. The plan is set out in Appendix 1 and will be implemented by a steering group.

The Director of Public Health and the Chief Operating Officer of CCG have agreed that the key partners of the steering group will comprise of representatives from the following organisations in keeping with national guidance:

- North Tyneside CCG - Commissioning and pharmaceutical leads
- North of Tyne Local Pharmaceutical Committee
- North Tyneside Healthwatch
- North Tyneside Council (Public Health, Communications and Engagement)

The steering group membership is set out in Appendix 2.

NHS England and NHS Improvement will be facilitating a meeting for PNA authors to share approaches and table queries.

## 5. Appendices:

Appendix 1 – Implementation Plan
Appendix 2 – Steering Group

## 6. Contact officers:

Steve Rundle, Head of Planning & Commissioning, NTCCG
Rachel Nicholson, Senior Public Health Manager, NTC
Suzy Cooke, Public Health Specialty Registrar, NTC

## 7. Background information:

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

The NHS Pharmacy Regulations 2013, updated the 5th December 2016

## 8. Finance and other resources

The costs will be met from within current resources.

## 9. Legal

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for this report.

## 10. Consultation/community engagement

The PNA must be developed in consultation with a range of stakeholders.
In keeping with the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations (2013). The following stakeholders were consulted in the production of the existing PNA and will be consulted again:

- North of Tyne Local Pharmaceutical Committee
- TyneHealth Ltd - GP Federation
- North Tyneside Clinical Commissioning Group (NTCCG)
- All persons on the pharmaceutical lists
- North Tyneside Healthwatch
- Northumbria Healthcare NHS Foundation Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust, and Northumberland, Tyne and Wear NHS Foundation Trust
- Newcastle and North Tyneside Local Medical Committee (LMC)
- All North Tyneside GP practices
- NHSE
- Neighbouring HWBs in Newcastle, Northumberland and South Tyneside
- VODA (Voluntary Organisations Development Agency)
- NHS NTCCG Patient Forum
- North Tyneside Council Residents' Panel

## 11. Human rights

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

## 12. Equalities and diversity

The PNA identifies the health needs of the local population including issues around access to pharmacy services, inequities in health experience and other inequalities experienced by specific groups in the population. During the public engagement process, it will be important to engage hard-to-reach groups and those with protected characteristics.

## 13. Risk management

Statutory obligations are failed to be achieved, if the PNA is not published by 1st October 2022.

## 14. Crime and disorder

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

**SIGN OFF**

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| Chair/Deputy Chair of the Board | X |
| Director of Public Health | X |
| Director of Children's and Adult Services | X |
| Director of Healthwatch North Tyneside | X |
| CCG Chief Officer | X |
| Director of Resources | |
| Director of Law & Governance | X |

**Appendix 1**

**Pharmaceutical Needs Assessment 2022**
**Implementation Plan**

| Date | Task | Lead | Purpose | Comments |
|---|---|---|---|---|
| Nov 2021 | **Set up steering group** members contacted (Appendix 2 – steering group members)<br><br>Two meetings to guide | Rachel Nicholson (RN) and Suzy Cooke SC) | To oversee the process of reviewing updating and publishing the PNA<br><br>Book Nov/Dec and May/June 2022 meetings | To agree the process, timeline and chair of steering group<br><br>Steering group to agree a draft PNA by mid-June 2022 |
| Nov/Dec 2021 | **Gather health and demographic data** | RN, SC, Steve Rundle (SR), Neil Frankland (NF) | Gather and analyse health and demographic data. | Highways, planning, transport and any developments will need to be taken account of. |
| Dec 2021 /Jan 2022 | **Updated pharmacy lists** | NHSE/I and LPC reps | To gather latest lists of pharmacies | |
| Dec 2021 /Jan 2022 | **Develop, agree and disseminate a Pharmacy Questionnaire to all contractors and a public questionnaire** | RN<br>SC<br>LPC rep<br>HWNT rep | To gather information on the nature of services provided by every Pharmacy in North Tyneside. Disseminate on PharmOutcomes<br>Public: gather info on how people access services. Support from Health Watch and Comms to engage hard-to-reach groups and those with protected characteristics | 2-week deadline for Pharmacies to complete followed by a mop up of non-responders.<br>4-weeks for public Q.<br><br>Support will be required from Policy, Performance and Intelligence (PPI) Team |
| Feb 2022 | **Analyse questionnaire and map services** | NTC Policy Performance and Intelligence Team | To identify and display the range of services provided by pharmacies across the borough | Support will be required from Policy, Performance and Intelligence (PPI) Team |
| March – end May 2022 | **Prepare draft PNA** | RN and SC | To ensure there is sufficient time for the required consultation period of 60 days | Deadline: June HWBB meeting |

| Date | Task | Lead | Purpose | Comments |
|---|---|---|---|---|
| Mid-June 2022 | **HWB to agree first draft PNA and consultation process for stakeholder and patients** | SR RN SC | To allow consultation period to commence | Agree who consulting with and why |
| Mid-June- mid Aug 2022 | **60-day consultation period with stakeholders and patients** | RN and SC | Consultation with key stakeholders/patients and presentation to Adult Social Care and Health and Wellbeing Sub Committee | Contact key stakeholders with the link to the draft document on the Council website invite comments or amendments via a single email contact |
| Aug/Sept 2022 | **Revise PNA and produce a final draft** | TBC | Revise PNA following consultation period taking account of comments and proposed amendments | |
| 15th Sept 2022 | **Present final draft to HWBB** | RN, SC and SR | Final draft of PNA to be agreed by the Board | |
| 1 October 2022 | **PNA published and valid for 3 years** | RN | PNA available on Council website | |

**Appendix 2**

**Suggested Steering Group Members**

- Chair – Rachel Nicholson Senior Manager Public Health, NTC
- Coordinator – Suzy Cooke Public Health Specialty Registrar, NTC
- CCG Commissioning – Steve Rundle Head of Planning and Commissioning, NTCCG
- CCG Pharmacist – Neil Frankland, Medicines Optimisation Pharmacist, NECS
- NTC Commissioning - Oonagh Mallon Commissioning Manager, NTC
- Health Watch – Paul Jones Director, NTHW
- Local Pharmaceutical Committee – Ann Gunning Community Pharmacy Lead, NoT LPC
- NTC Communications – Laurie Watts Communication Manager, NTC

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