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 home care; adaptations and loan equipment service; telecare including falls first responder service; and seven day social work including bank holidays.
- 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.

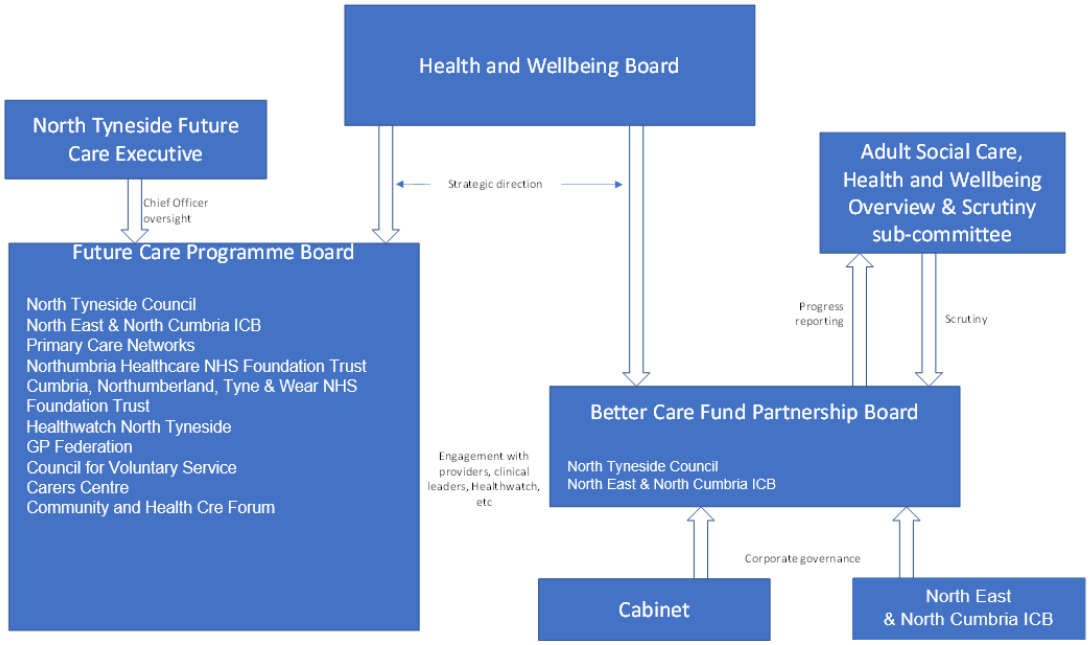
The Disabled Facilities Grant (DFG) will be used to enable people to live independently in their own home; minimise risk of injury for customer and carer; prevent admission to hospital and long term care; reduce dependency upon high level care packages;

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 were developed with a rehabilitation ethos with the aim 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 has 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 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. This Governance structure is expected to continue under the place based arrangements within the North East and North Cumbria Integrated Care Board (referred to as the ICB).



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

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 who works closely with the Director of Housing to ensure strategy lines up with overall Housing priorities. This senior officer 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 officer 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 officer 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.

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.

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. More so, since the start of the Pandemic, we have seen increasing need for collaboration, joint working and integrated services to meet the health and social care needs of the borough.

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. Plans for improving flow and discharge are summarised below;

Plans for 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.

Plans for improving discharge:

- 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 5 days per week.
- 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.

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 (48 hour) 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 have trained and deployed 16 Community Nurse Practitioners attached to PCNs 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. We are also developing contingency plans to

commission additional community beds as part of a major incident response to winter pressures and/or covid surge.

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 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 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 is under development to replace current 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

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;

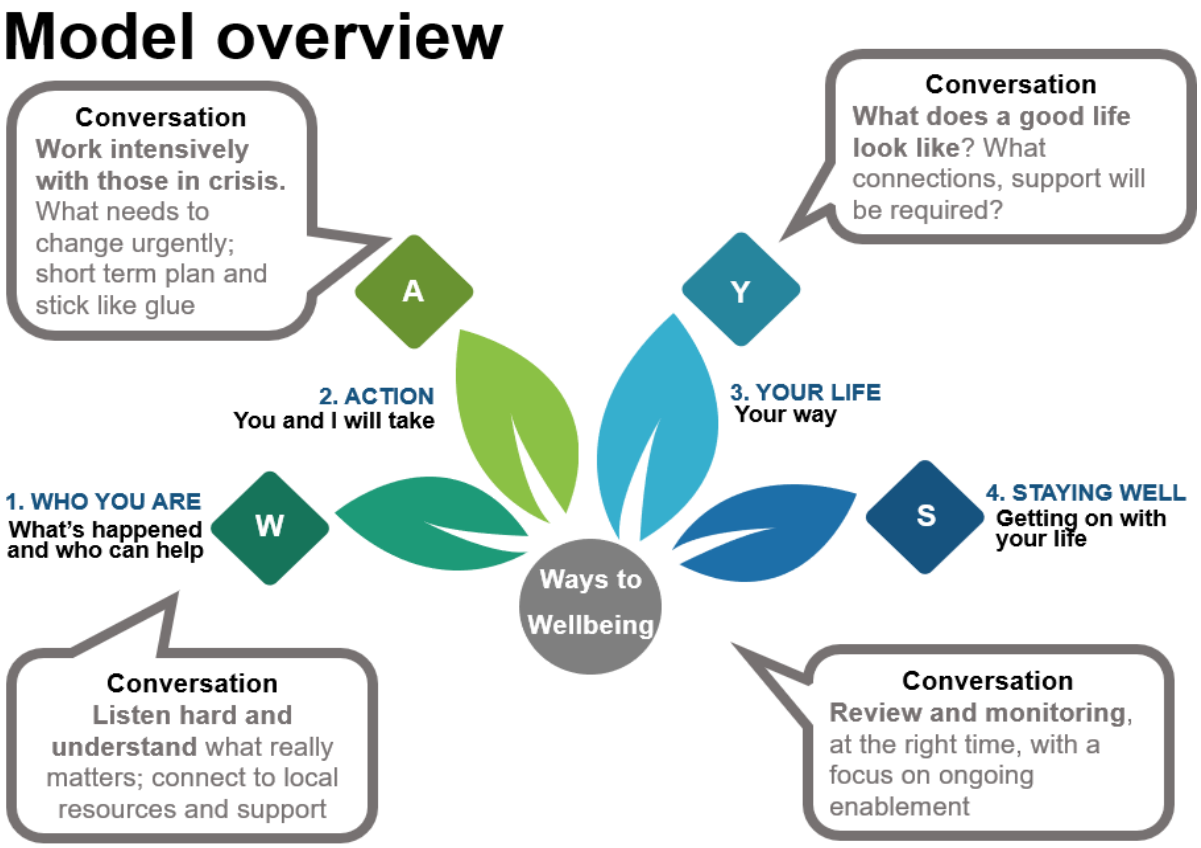
- describes our approach to working with adults
- is values-based and transformative
- is responsive to challenges that our customers face
- provides consistent knowledge, tools and skills for staff
- enables great quality of practice

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

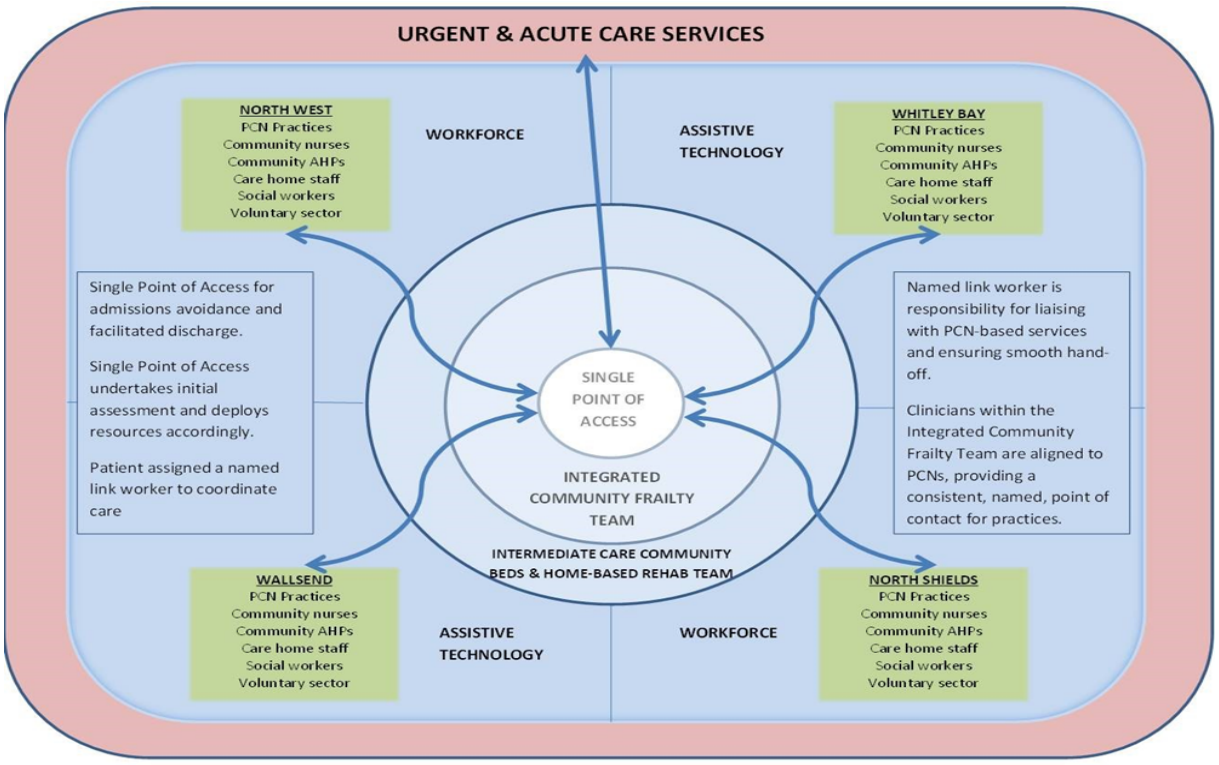


The Integrated Frailty Service

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 2: 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.

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.

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.

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)

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 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 receive reablement.

Figure 3: Age bands of clients receiving reablement

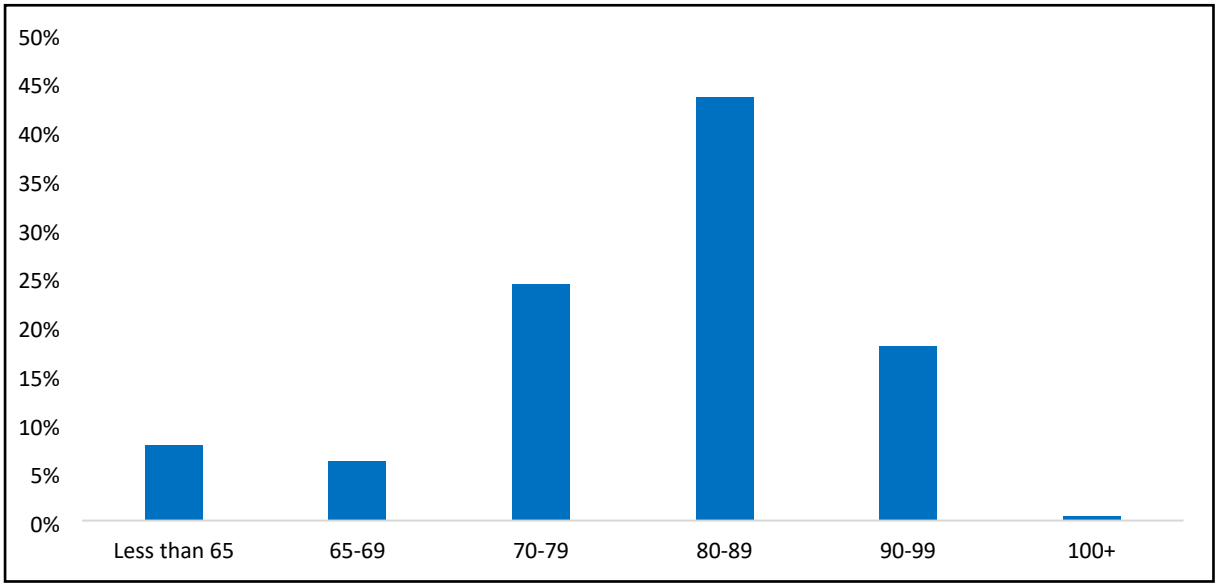


Figure 4 below shows that ethnic minority patients are very slightly more likely than white patients to be discharged from hospital to their usual place of residence. This trend has reversed compared to 2020/21

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

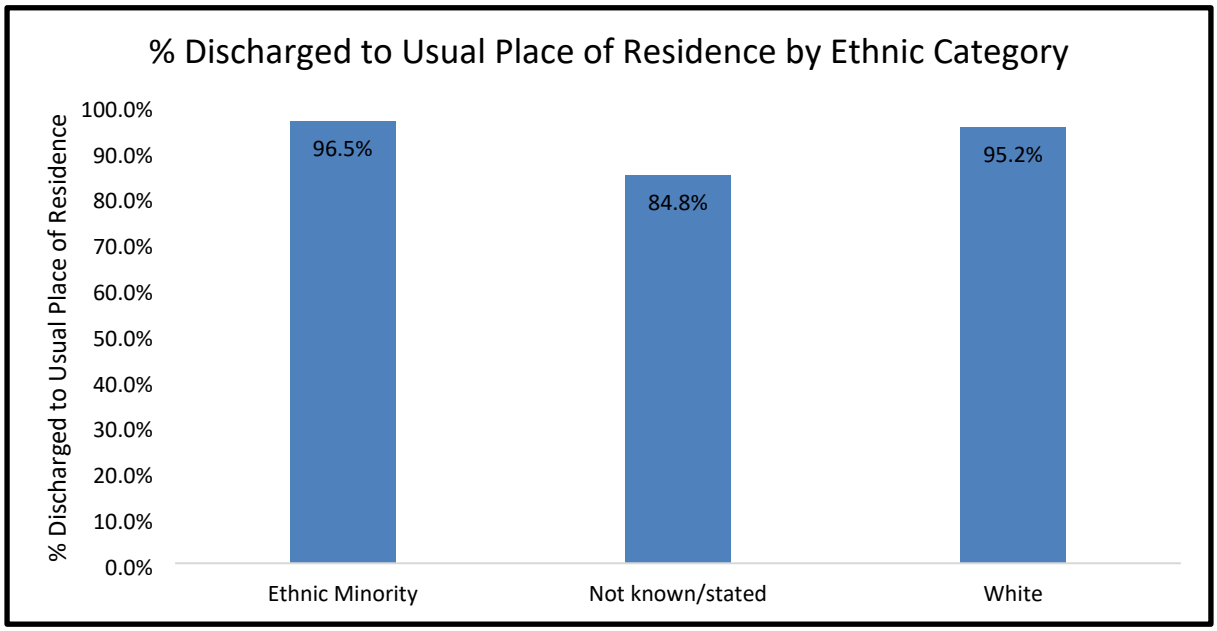
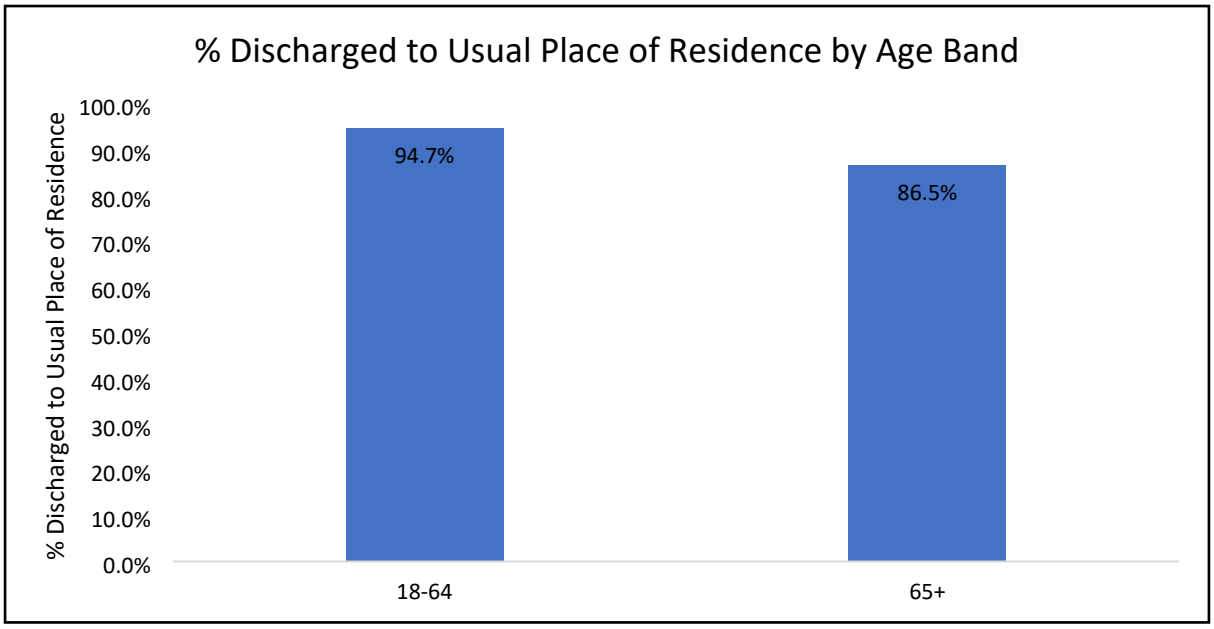


Figure 5 shows that the probability of being discharged to usual place of residence declines with age. The majority of our BCF services are focused on older people in response to the growing levels of need in the older age groups.

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



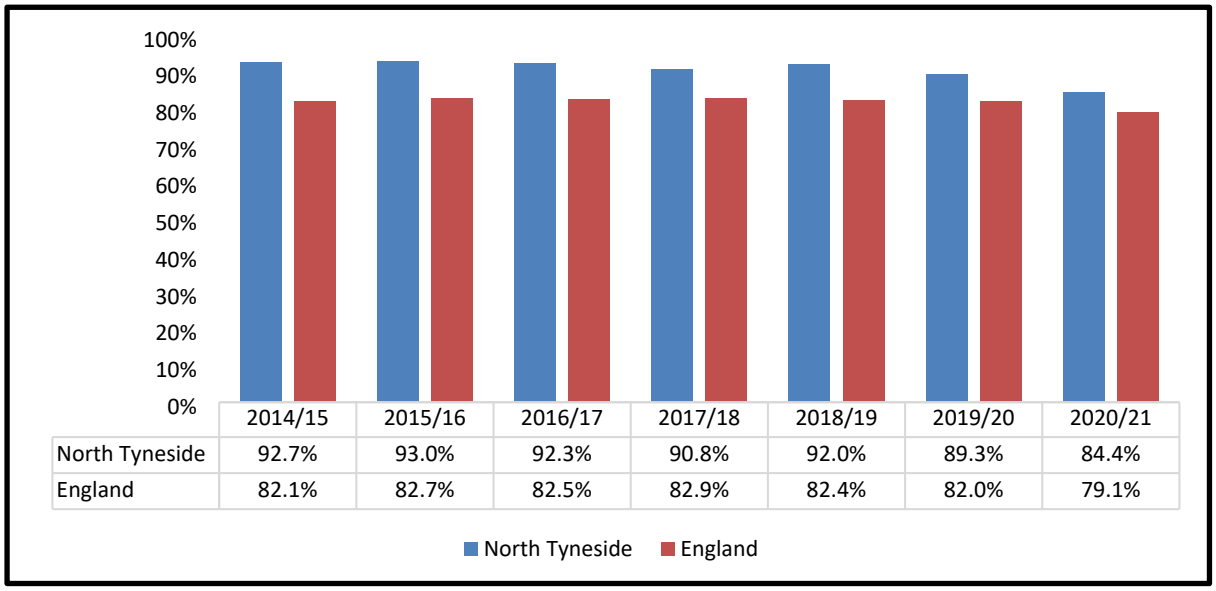
Appendix 1 - BCF Metrics

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 (national comparative data is not yet available for 2021/22). Due to recent issues with recruitment and retirement of experienced staff, we have set the target for 2022/23 at 90.0%. The service has undergone restructuring to provide an optimum skill mix and provide career development opportunities for staff to progress within the service and the target aims to maintain the performance from 2022/23 while new staff and the new structure bed in.

Figure 6: Effectiveness of reablement metric, time series

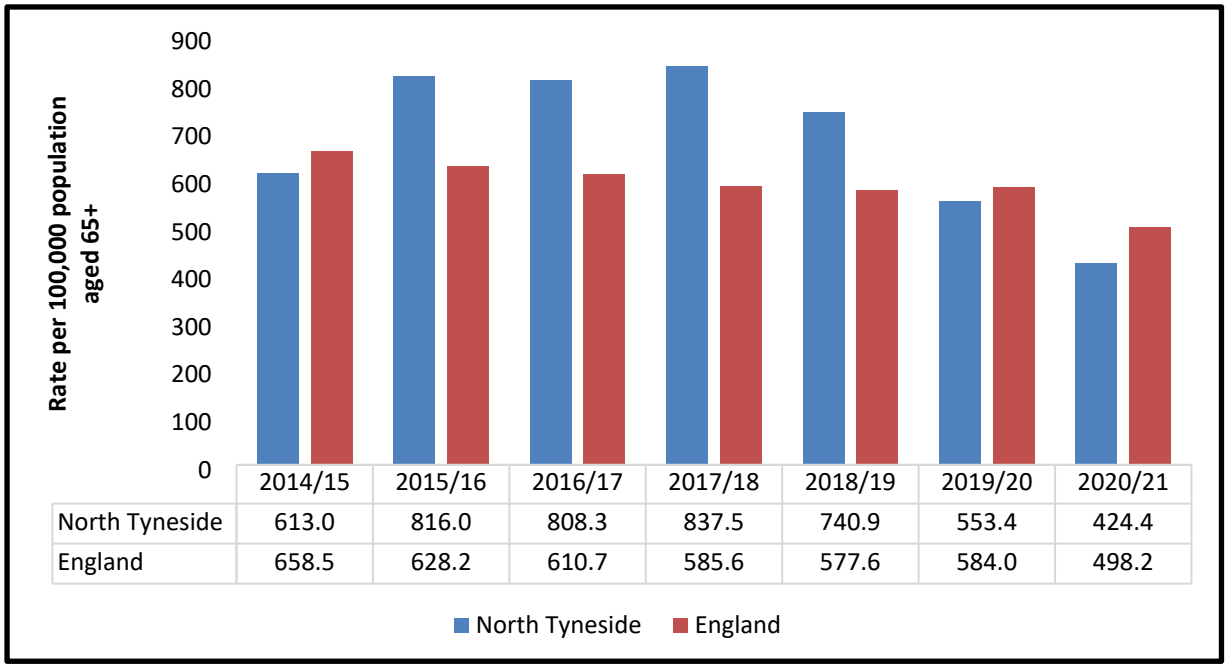


	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
North Tyneside	92.7%	93.0%	92.3%	90.8%	92.0%	89.3%	84.4%
England	82.1%	82.7%	82.5%	82.9%	82.4%	82.0%	79.1%

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 where national comparatives are available. 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. The outturn for 2021/22 was 423 admissions.

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 2022/23 we expect the outturn to be 402.3 admissions per 100,000 people aged 65+ delivering a 5% improvement on the outturn for 2021/22 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.

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

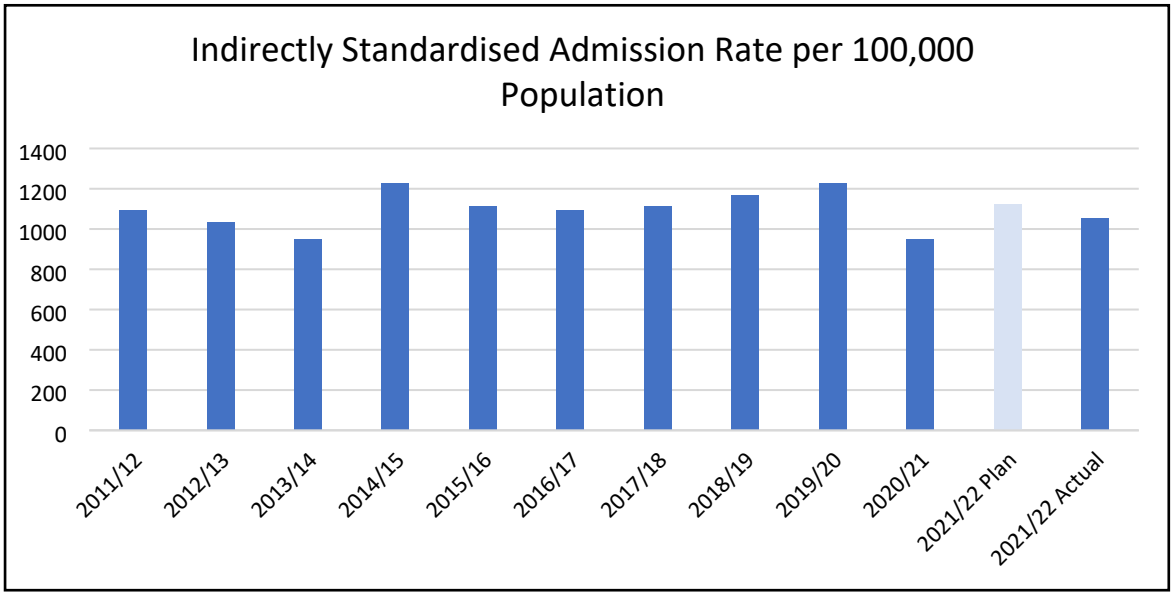
- Up to 2021/22 there were nine extra care schemes across North Tyneside with 375 apartments. Most of these are rental but a small number are shared ownership. Extra care offers individuals the ability to continue to live in the community, at home and have access to on-site care and support through a 24/7 commissioned care team. All apartments are self-contained and individuals are supported to maximise the maintain their independence.

- A further two extra care schemes with 104 apartments came on stream at the end of 2021/22. One of these schemes with 40 beds is dementia specific and offers 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 an indirectly standardised rate per 100,000 people. In 2021/22 North Tyneside's actual performance of 1052.89 was within the target of 1125.

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



Our ambition for 2022/23 is a rate of 1044 which is the average performance in the region and would represent a modest improvement but a significant improvement against the last pre-Pandemic year's result of 1229.4

BCF services will impact this goal by:

- The Enhanced Care in Care Homes service 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 2022/23.
- 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.

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

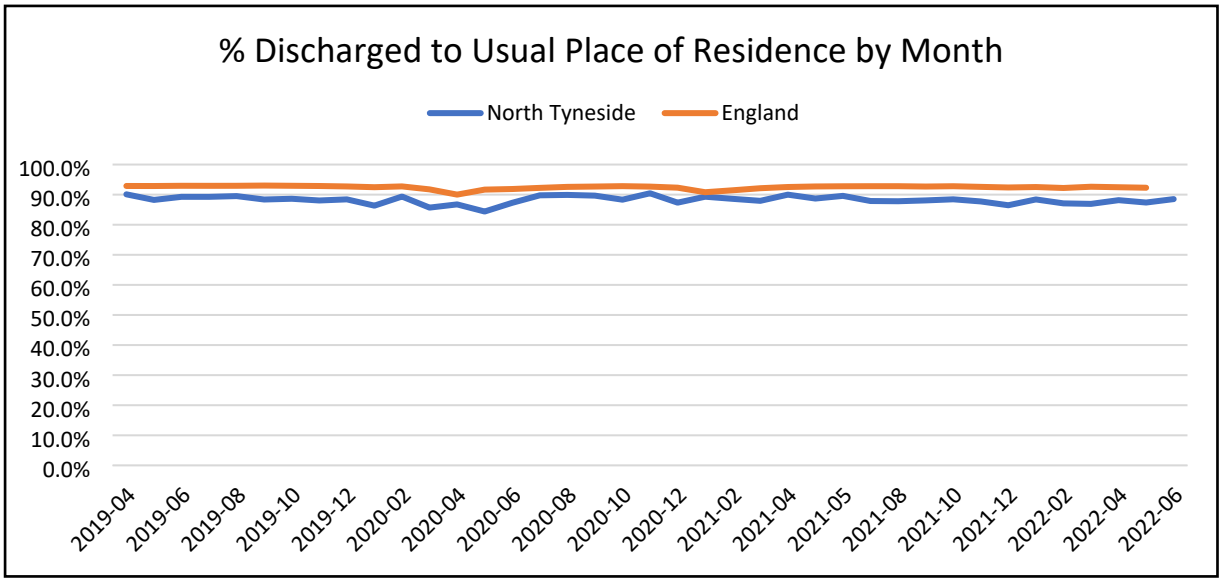
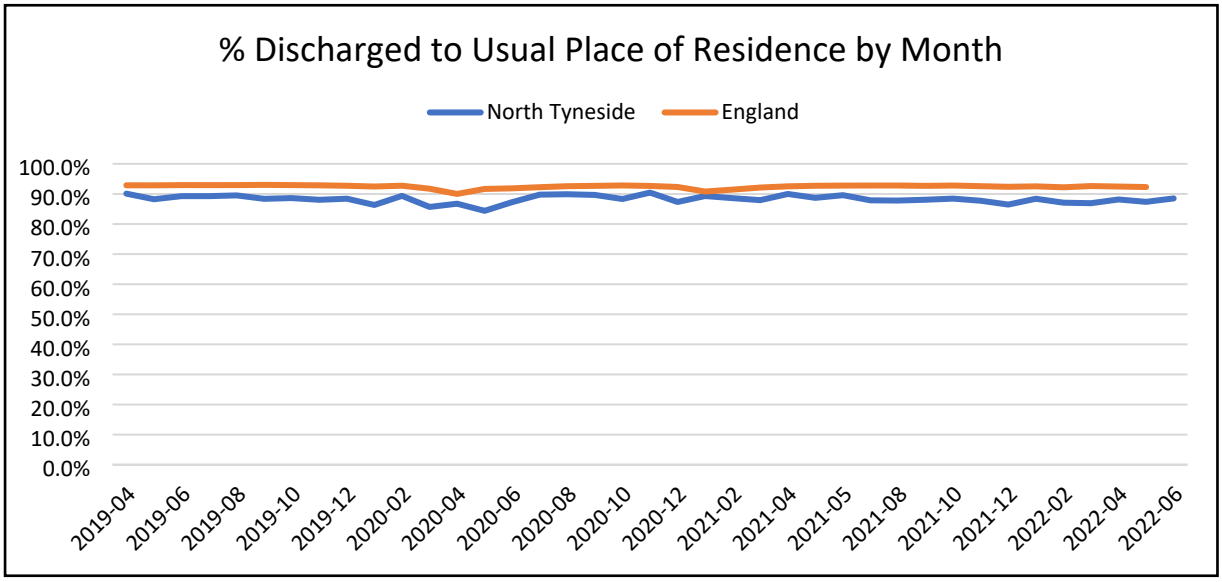


Figure 9 below shows the proportion of people discharged to their normal place of residence from April 2019 to August 2021. The rate for North Tyneside was below the England average throughout the period, by an average of approximately 4%.

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



The outcome for 2021/22 was 88.1% and it is proposed that the target for 2022/23 is 89.0% representing a small improvement in line with North Tyneside's recent performance and moving closer to the England average.

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.

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 CCG Contribution	9,626,721
27	Community-based support	Health contribution to CarePoint	Community Health	Minimum CCG Contribution	2,674,748
2	Intermediate Care beds	Intermediate Care	Community Health	Minimum CCG Contribution	3,616,877
3	Intermediate Care - Community Services	Community Rehabilitation Team	Social Care	Minimum CCG Contribution	963,456
4	Liaison Psychiatry - Working Age Adults	Liaison Psychiatry - Working Age Adults	Mental Health	Minimum CCG Contribution	858,351
19	End of Life Care - RAPID	End of Life Care	Community Health	Minimum CCG Contribution	262,987
8	Improving access to advice and information	MyCare and Living Well in North Tyneside digital services	Social Care	Minimum CCG Contribution	40,355
9	Care Act implementation	Care Act implementation	Social Care	Minimum CCG Contribution	825,131
10	Carers Support	Carers Support	Social Care	Minimum CCG Contribution	749,107
12	Independent Support for People with Learning Disabilities	Independent Support for People with Learning Disabilities	Social Care	Minimum CCG Contribution	802,614
13	Impact on care home fees of	Meet costs of paying living wage	Social Care	iBCF	2,718,394

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	557,279
	Step down – extra care	Provision of additional extra care beds for short term use	Social Care	Discharge Funding	470,205
	Expand homecare capacity	Support the development of additional homecare capacity	Social Care	Discharge Funding	252,283
	Welfare assistance	Welfare assistance at our hospital based single point of absence to remove barriers to discharge	Social Care	Discharge Funding	10,000
	Pathway development	Project management to improve the efficiency and effectiveness of discharge pathways	Social Care	Discharge Funding	38,126
	Transport	Additional transport to remove barriers and speed up discharge	Social Care	Discharge Funding	15,000

Scheme ID	Scheme Name	Brief Description of Scheme	Area of Spend	Source of Funding	Expenditure (£)
	Step down beds - nursing	Provision of 10 additional step down nursing care beds	Social Care	Discharge Funding	557,280
	GP cover for step down arrangements	GP cover for step down arrangements	Social Care	Discharge Funding	100,000
	Pathway development	Project management to improve the efficiency and effectiveness of discharge pathways	Social Care	Discharge Funding	38,126
	Step down beds extra care	Provision of additional extra care beds for short term use	Social Care	Discharge Funding	168,251
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