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 was our place-based planning mechanism. New place based arrangements are now in the process of being established following the creation of the North East and North Cumbria Integrated Care Board.

Our Better Care Fund Plan is centred around delivering against the BCF policy objectives to:

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

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

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

The Improved Better Care Fund element will be used to support the social care market to ensure the right care is available, including meeting the costs of paying at least the National 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) is used to enable people to live independently in their own home; minimise risk of injury for customer and carer; prevent admission to hospital and long term care; reduce dependency upon high level care packages; improving quality of life and wellbeing; maintain family stability; improve social inclusion; and enhance employment opportunities of the disabled person.

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

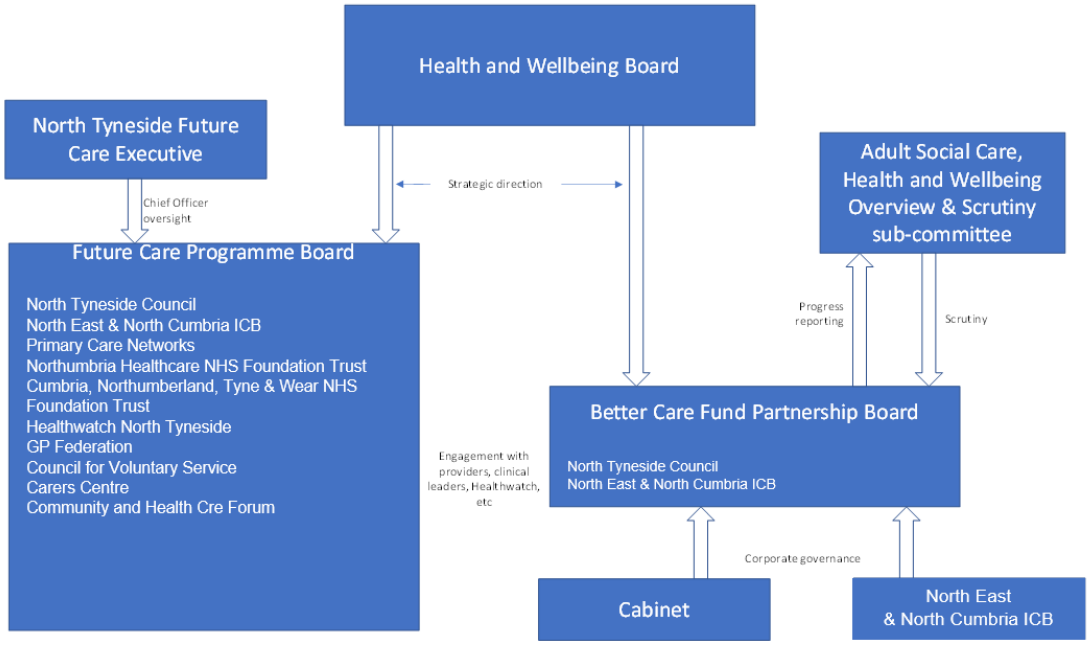
This plan provides continuity with the previous BCF plan. The COVID-19 pandemic accelerated the provision of hospital discharge services based on a “home-first” approach, which was already under way. Our priorities for 2023-25 and beyond are to continue the progress in the establishment of the integrated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

Governance and Consultation

The plan has been developed jointly by the Local Authority and ICB in consultation with the local acute trusts (Northumbria Healthcare NHS Foundation Trust and Newcastle upon Tyne Hospital NHS Foundation Trust). Mental health and learning disability providers were also consulted and were involved in looking at ways to invest the Discharge Support Fund.

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 was our place-based planning mechanism. The Future Care Programme Board included representatives of the local NHS providers (acute, mental health and primary care), social care, primary care networks, representatives from the voluntary sector, North Tyneside Carers Centre, and the Community and Health Care Forum. As such, wide representation from a full range of stakeholders took part in developing the Better Care Fund Plan 2023-25.

Figure 1: Governance model in operation to date (and in place during development of BCF Plan 2023-25)



Governance arrangements are however, now in the process of being redeveloped.

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

The HWB agreed a new Health and Wellbeing Strategy – 'Equally Well' in November 2021. This strategy informed the development of the Northeast and North Cumbria Integrated Care Partnership (NENC ICP)– 'Better Health and Wellbeing for All' which was published in December 2022.

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

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

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

implementing the key priority of the strategy in relation to health and social care integration.

It is also proposed that a local joined up approach to communication and engagement could be established to support the work of the Executive and ensure that local people are at the heart of the decisions that are made. Representatives could include Healthwatch, the Patients Forum, Community Health Care Forum, VCS, Carers Partnership ensuring that the wider stakeholder group continues to have a voice in how health and social care integration is delivered through the Better Care Fund.

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

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

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, and agrees and manages a Section 75 Agreement to give effect to the BCF plan.

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

National Condition 1: Overall approach to integration

Central to the Future Care programme has been a vision to deliver a patient centered sustainable health and social care system and this ethos will continue under the new place based arrangements 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. Action is under way to further develop services for older people, which will lead to reconfiguration of some services included in the BCF, within the overall financial envelope set out in the BCF Plan.

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

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

Collaborative Commissioning

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

BCF funded services support this approach through;

- Community-based services, which includes CarePoint - our multi-agency, multi-disciplinary integrated team which delivers a home-first approach to hospital discharge and admission avoidance; reablement; immediate response and overnight home care; adaptations and loan equipment service; telecare including falls first responder service; and seven day social work.

- Intermediate Care beds, including bed-based facilities complemented by a community rehabilitation team
- Out of hospital community health services
- A hospice-at-home service for end of life care
- Liaison Psychiatry for working-age adults
- Support for people with learning disabilities to live independently at home
- Implementation of the Care Act, support for carers, and the provision of advice and information.
- A range of step down facilities to support discharge and maintain hospital flow with the ultimate aim of getting residents home

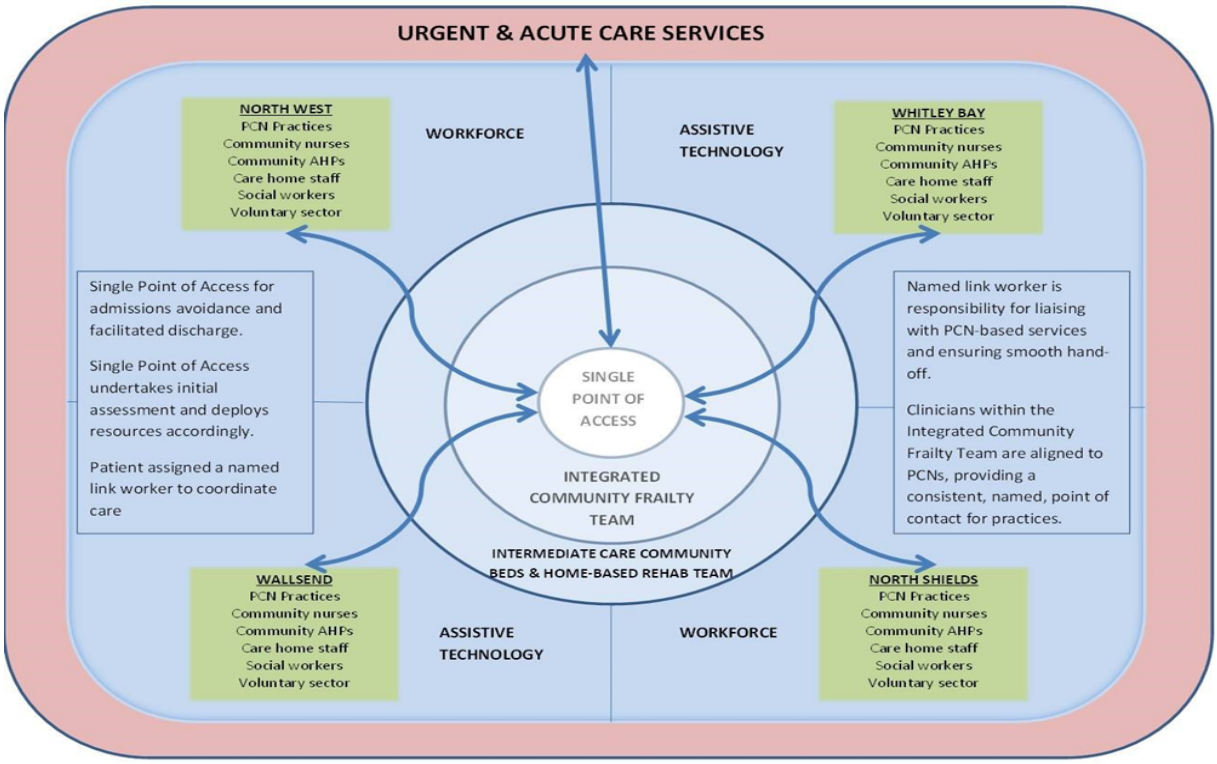
National Condition 2: Enabling People to stay well, safe and independent for longer

The Integrated Frailty Service

An Integrated Community Frailty Service for North Tyneside continues to be developed through the reconfiguration of Care Point, Care Plus, Jubilee Day Hospital and intermediate care beds.

- Ongoing development of an integrated frailty service within existing NHS and Local Authority services contracts.
- The proposed development of a new community bed based intermediate care facility at Backworth in North Tyneside, which would 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.

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:

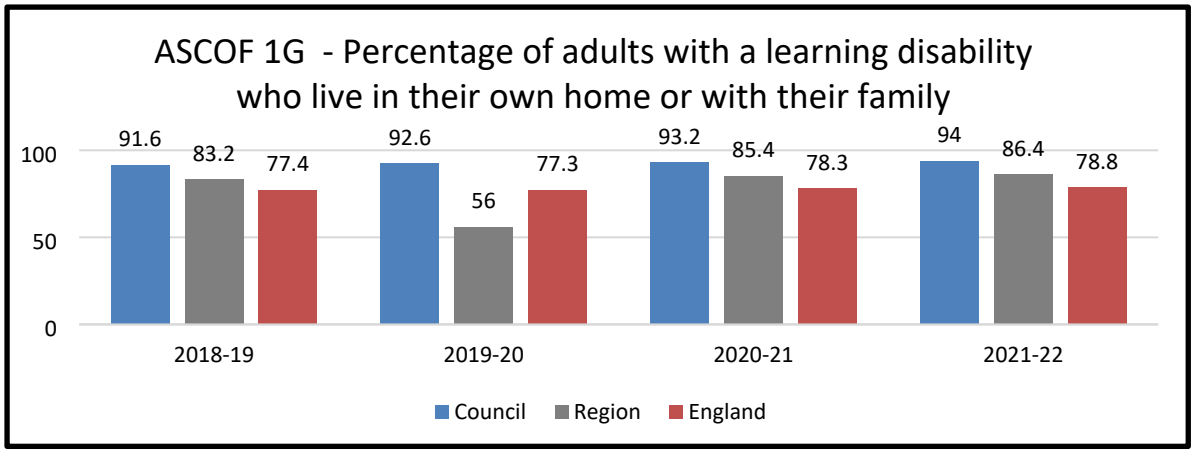
Liaison Psychiatry for Working Age Adults provides an interface between psychiatry and medicine focusing on providing improved management for patients with co-morbid physical and mental health conditions.

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 by supporting an approach that wherever possible people with a learning disability will be supported to live independently at home. Better Care Fund investment contributes to the Local Authority having a high proportion of residents with a learning disability who live in their own home or with family with a high level of supported living provision.

Figure 3: Percentage of adults with a learning disability supported to live in their own home or with family



Also 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. This funding has been used to support fee increases above the national living wage for homecare and extra care providers with a view to maintaining and growing capacity to support residents to live at home with the support they need to remain safe and as independent as possible.

Collaborative Commissioning

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

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

Anticipatory Care

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

In North Tyneside, anticipatory care is part of the strategy for the development of the Integrated frailty service (Ageing Well). The Better Care Fund supports the Care Point service which 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 hour Urgent Community Response (UCR). We are in the process of streamlining existing Care Point services and Jubilee Day Hospital into an integrated hub, which includes bed based intermediate care. We are developing "spokes" and Multi Disciplinary Teams within each Primary Care Network.
- We are deploying 16 Community Care Practitioners across the hub and spokes as part of this integrated frailty programme and are developing a model in community services for Long Term Condition management, including mapping demand and workforce planning to meet need. We have developed and costed a delirium at home model and are incorporating the Community Falls Clinic within the Integrated Frailty Service.

Strengths Based Approach

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

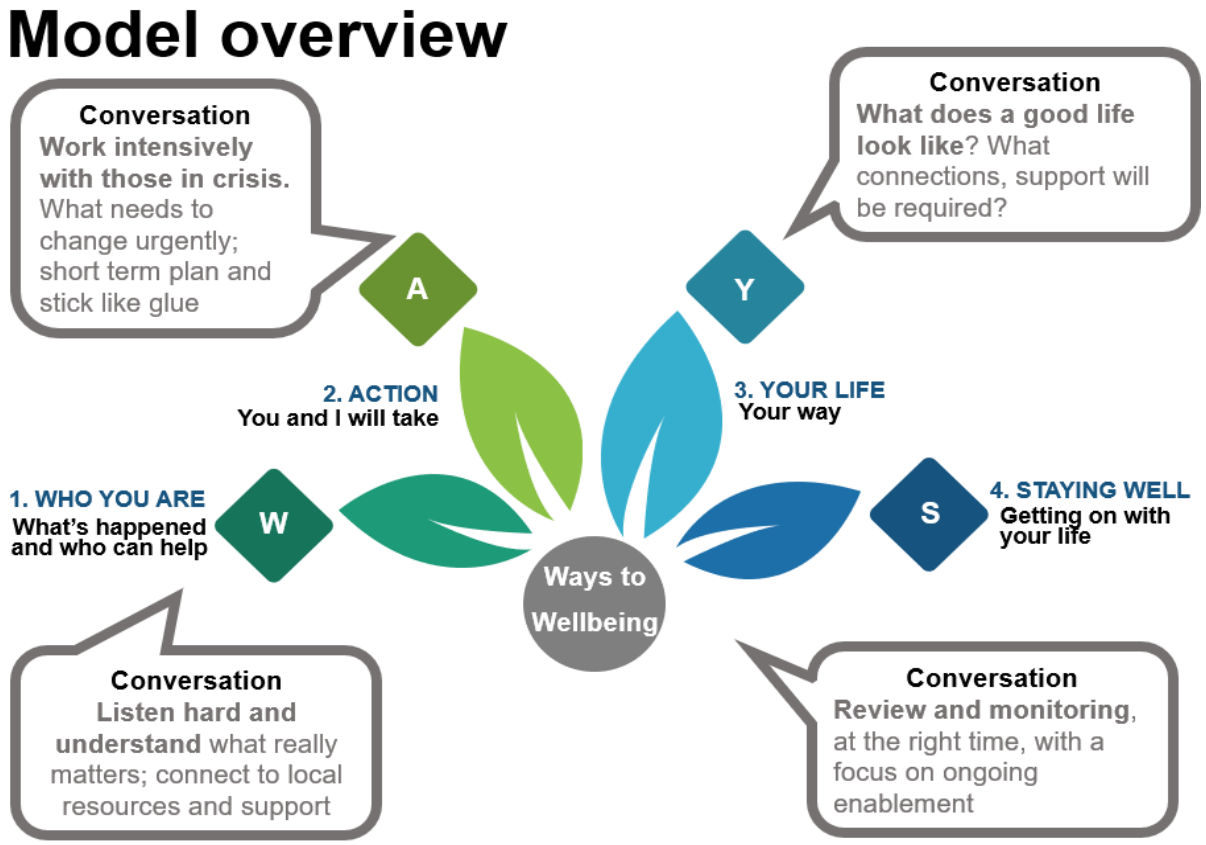
- describes our approach to working with adults
- is values-based and transformative
- is responsive to challenges that our customers face
- provides consistent knowledge, tools and skills for staff
- enables great quality of practice

The underlying principles of the model are:

- Always start the conversation with the strengths of people, families and communities
- Always exhaust conversations 1 and 2 before conversation 3 (see Figure 1 below)
- Never make a long-term plan in a crisis
- Stick to people like glue during conversation 2 – support people to regain control of their life
- No hand-offs, no referrals, no waiting lists, no pending cases
- Listen to people – understand from their perspective
- Know the neighbourhoods and communities that people live in

- Work collaboratively with members of the community, networks, and support system
- Strengthen focus on maximising family support, and keeping people connected to communities
- Use **technology** wherever we can

Figure 4: The "ways to wellbeing" practice model



Capacity and Demand Planning

Our capacity and demand planning work has indicated that our capacity in beds is higher than demand predicted by the John Bolton Model while there is a shortfall of capacity in reablement and rehabilitation at home. We have a gap in capacity in terms of low level social support which could be provided by the voluntary sector.

Hospital demand has been modelled by using discharge data from previous years as an indicator of future demand. The discharge data for 2022/23 in particular has been used to model numbers of discharges and the profile of activity across the year. It is interesting to note that there was not a strong seasonal signal across the year. Anecdotally teams recognised that winter is now a year-round phenomenon.

The average discharges per day taking place in each month is shown below showing the rate is fairly steady throughout the year.

	2022/23	2021/22
April	56.43	52.97
May	55.84	55.77
June	56.53	57.83
July	56.10	53.23
August	57.16	51.58
September	58.67	55.37
October	58.19	55.29
November	61.63	59.27
December	54.35	56.52
January	56.32	53.97
February	56.61	56.46
March	55.35	58.48
Average	56.93	55.56

In relation to low level support, we intend to undertake a pilot with the voluntary sector in the second half of 2023/24 to identify how a package of support could be made available to better facilitate discharges where patients require a short period of additional support to settle back at home. This is to be funded from the discharge Support Fund with the intention of expanding this approach in 2024/25 when more funding is available.

In terms of short-term service capacity, we are reviewing how we are using the reablement service taking into account the fall in our metric for effectiveness of reablement resulting from a higher level of deaths and admissions to residential care following an episode of reablement. There is concern that the shortage of long-term capacity within homecare has resulted in reablement being used to expedite discharges home but where the potential for further maximisation of independence is limited. Our review will focus on ensuring the criteria for referral into Reablement remain appropriate and are being applied consistently and ensuring that once clients have maximised their potential to improve, they are moved into longer term arrangements in a timely way. Capacity from Reablement is also being used to work into the step-down residential beds and the step down extra care facilities to ensure that clients maintain and regain skills which will enable them to return home after a further period of convalescence.

We recognise the need demonstrated by the demand and capacity modelling to increase non bed based intermediate care however, the need to expedite discharges led us to increase bed-based capacity from October of 2022 using funding made available through the newly announced Discharge Support Fund. A total of 20 short term residential and nursing beds were commissioned and operated throughout the winter of 2022/23. These beds were well used for a frailer cohort of patients where, with further time to recover and with reablement input, it was hoped that the majority of clients would return home. We took the decision to maintain the stability of the local arrangements supporting discharges to continue to commission these beds in 2023/24 using the Discharge Support Fund element of the BCF. These 20 beds are expected to be available throughout 2023/24 with a further evaluation taking place in the second

half of the year with a view to moving some of this capacity into a home-based provision in 2024/25.

The shortage of long-term domiciliary care has, on occasions, led to patients being admitted to step-down residential care beds in order to facilitate a timely discharge from hospital. In many cases these patients could have gone directly home if the domiciliary care capacity had been available at the right time.

Our aim is to reduce reliance on bed based intermediate care and to increase capacity in home-based care in line with the gaps/oversupply identified in our planning process. The limiting factor however, has been workforce shortages which has particularly impacted capacity in homecare and home based reablement leading to the short term investment in additional step down beds. We have plans to invest in additional home-based capacity provided by the Local Authority funded through the Discharge Support Fund with the recruitment of 20 additional 25-hour carer posts expected to be in place from October 2023. These posts will work with clients discharged from hospital with more complex needs using a reablement ethos to maximise independence and minimise ongoing care needs. The intention would be then to commission the external sector to provide ongoing long-term care as required. The inhouse homecare team has demonstrated their effectiveness in significantly reducing packages previously held by the independent sector for example, safely reducing double carer packages to a single carer with reduced visit time enhancing independence and providing less intrusive care.

We have plans to pilot different approaches to commissioning home-based support during 2023/24 with a view to easing recruitment and retention issues and increasing available capacity for example commissioning on an outcomes basis and paying providers on a shift basis rather than a visit basis.

The Local Authority has also recently established a Care Academy as a one stop shop to provide the market with a pool of prospective employees who are suitably trained, have completed their disclosure and barring service checks, and have a desire to work in social care. The Care Academy will work proactively with schools and colleges, training organisations and employers to increase the number of staff recruited into social care and then retain them through supporting ongoing professional development for workers and supporting care providers to be excellent employers.

Ongoing dialogue with Jobcentre Plus is identifying potential employment opportunities for people who have not had stable employment, while being mindful that reliability is a key attribute for anyone wishing to work in the care sector. In the last year there were 87 Academy enrolments. Of these referrals 43 were unemployed people from Jobcentre Plus and of these 15 people progressed into employment. 28% completed remote learning, 16% were registered unpaid carers and 8% were already working in the care sector. The Academy will review the success of those who have secured employment to help identify future enrolees and identify other routes into the Academy, including local schools and colleges. In addition to recruitment, eleven moving and handling courses have been supported by The Academy's facilities, and this helps providers ensure that staff are working safely.

North Tyneside staff have been actively involved in the national Made with Care recruitment campaign with a video of one of the Lead Practitioners sharing the

highlights and benefits of working for the council. A virtual jobs fair was held in November 2022 and we featured the council's HR team who promoted careers in social care. We know that 133 people watched this live for an average of 34 minutes each.

We have taken forward the learning from developing the capacity and demand plan and the learning from the evaluation of the wider social care capacity and demand work under the Market Sustainability and Improvement Fund. We have already witnessed some improvement in homecare capacity but, in the first quarter of 2023/24 are carrying a list of around 60 clients who are waiting for a domiciliary care package.

We have an improvement plan designed to further improve capacity within the external homecare and extra care sectors to support more long-term packages of care.

This plan is shown below;

Theme	Action	By When
Homecare contract	▪ Continue to pay above inflation fee increases to support providers to pay the Real Living Wage supporting provider recruitment ▪ New procurement to commence in late summer 2023 to feed into the award of new contracts from April 2024. ▪ Undertake pilot work in advance of this with small number of providers to test out proposed changes / improvements. ▪ Further develop assistive technology as art of the baseline home care offer to support people to live independently. ▪ Review amount and delivery of double handed care – generally in place to support moving and handling for individuals. ▪ Develop internal home care offer, currently out to advert for care assistant posts, review and refine hospital discharge pathways and links into external sector provision. ▪ Continue to embed HomeFirst model for discharge from hospital. ▪ Review micro-commissioning arrangements and current delivery across North Tyneside to minimise / reduce down time / travel time (and subsequently cost) of individual packages of care.	April 2023 April 2024 September 2023 September 2023 September 2023 October 2023 On-going
Extra care	▪ Review current occupancy and access arrangements into extra care, including identified link workers in social work teams. ▪ Review how we promote extra care and ensure this is an option for consideration	August 2023 August 2023

Theme	Action	By When
	before a care home placement is considered / agreed. ▪ Review requirement for new / additional extra care provision in NE of the borough (Whitley Bay), where there is currently no provision and creates difficulty when alternatives to care home placements are to be considered.	July 2023
Care academy	▪ We have established our North Tyneside Social Care Academy, review this soft launch. ▪ Feed into regional work across NE ADASS area on care academies, how they operate, best practice etc. ▪ Recruit into Development Officer post to deliver improvements to the Care Academy, promote etc. ▪ Further discussions with NHS colleagues across the ICB (North Tyneside place) and Northumbria Healthcare Trust (local in-patient and community provider) about Health Care Academy and potential for join up.	July 2023 July 2023 August 2023 On-going
Workforce strategy	▪ We have an Adult Social Care Workforce Strategy that covers internal Local Authority staff – social work and direct provision. ▪ Review and extend to include external market. ▪ Engage with providers across different sectors, client group, age areas to ensure their requirements are covered, ▪ New updated whole system wide workforce strategy in place to support: ○ Recruitment ○ Retention ○ Development ○ Support for providers ○ Support for new employees and existing employees	April 2023 September 2023 September 2023 October 2023
Market engagement	▪ The whole of this delivery plan is supported by engagement with the market, groups of like providers as well as individual providers, through: ○ Individual webinars, group sessions ○ Using existing provider forum networks	On-going

Theme	Action	By When
	○ Adult Social Care Commissioning fortnightly newsletter to providers and the market	
Direct payments	▪ Improve use of and access to direct payments and access to Personal Assistants as an alternative to commissioned care and support. ▪ Review direct payment support offer, how this can be accessed and scope of delivery.	March 2024 March 2024
Winter planning 2023	Over and above the actions identified already in this plan, we will: ▪ Continue throughout the summer and autumn to meet with NHS partners and others to plan for winter 2023. ▪ Monitor the outcomes and usage of the ASC Discharge Fund to ensure it is achieving value for money, alongside the key outcomes identified in the grant conditions. ▪ We will review what we have done in winter 2022, to see if we can do more of what went well, improve what didn't go so well and look at other areas across the NE and wider afield to identify best practice we would implement in North Tyneside.	

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

Supporting Hospital Discharge

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

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

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

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 were put in place with 14 beds identified within extra care schemes 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 with a further amount being identified to remove barriers to discharge around transport. Funding has also been identified to provide programme management support to improve the efficiency and effectiveness of discharge pathways.

The main BCF also funds:

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

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

Improving flow:

- Trusts have in place Discharge Boards at which all potential discharges are discussed each morning in the Site Brief. Length of Stay meetings take place, the frequency of which depends on current system pressures
- Discharge lounges are either already in place or are being established and dedicated transport is in place to move patients between hospital sites.
- Trusts work to ensure prompt transfer from the discharge lounges (1 hr for pathway 0 and same day all others).
- Local authority discharge teams work very closely with Trusts to ensure that the onward transfer from discharge area is undertaken as promptly as possible (7 day basis), aiming to meet national requirements for the majority of patients to be transferred in 2 hrs or same day.

- Improvements in data availability with updates to the Acute and Community Daily Discharge Situation Reporting Questions provided.
- Social circumstances and care needs are included in the admission sections of all nursing and medical documentation. Community discharge teams are involved at the earliest opportunities where any level of complexity or ongoing care is required. Proactive assessment for referral to intermediate care settings take place.
- Full implementation of the Discharge to Assess model in line with discharge policy percentages are in place. Data is reviewed to ascertain if the national discharge funding had an impact on flow and to inform discussions with partners on the challenges in the systems and work towards solutions.
- Recruitment to specific posts is being considered where it has been identified that this will be of benefit such as a System Flow Coordinator post. Additional specialist care home support team staff, District Nursing staff and Community and Rehabilitation Team staff are being recruited where appropriate.

Improving discharge:

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

Supporting Unpaid Carers

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

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

The provision of good quality advice and information and emotional support for carers is critical. Contingency planning and respite provision can be integral to enable carers, whether they care for older relatives, people with learning disabilities, people with a mental health problem, or people with physical disabilities to continue to undertake their caring roles and continue to be a valued part of their community.

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

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

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

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

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

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

Respite / Short-break services

The support many carers require involves a service delivered to the person they care for including residential short break and respite services and forms of domiciliary care and day care. Other forms of support are often provided by access to a peer support group, training or being provided with advice and information on the condition of the person being cared for. Funding from the BCF allocation is used to support the cost of these services.

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

Disabled Facilities Grant (DFG) and wider housing services

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

The DFG aims to:

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

We are currently reviewing our policy with a view to further widening the ways we use this fund to be able to better support our residents safely at home. The current policy is meeting current demand for adaptations however we have had underspends against the fund in recent years.

The current policy outlines the following uses for the grant:-

- Any adaptation that costs less than £10,000 will not involve a means test allowing adaptations to be delivered quicker, expediting hospital discharge, reducing care package costs, and preventing admission to hospital or residential settings.
- The Grant can be used to remove a Category 1 Hazard under the Housing Health and Safety Rating System, where there is assess need. This national system for assessing risk in homes defines a Category 1 Hazard as one posing a serious threat to people living in or utilising a home (for example poor wiring or heating). In line with national best practice, local housing need and the experience of our healthy homes work, the evidence shows that this will allow improvements to poor quality owner-occupied or rented property where the resident has an assessed need to prevent escalation of that need and further care costs
- The upper ceiling of the Grant was increased from £30,000 to £40,000;
- The Grant can be used in specific cases for homes out of North Tyneside, where the Council is responsible for care costs.
- The Grant will be used for equipment to meet assessed need; over time, the overlap between “equipment” and “adaptation” has become greater. The policy will allow the Grant to be used for items of equipment, where that item is specific to assessed need and can be seen to prevent additional care costs
- The Grant will allow for maintenance of the asset, for example by including maintenance arrangements in the initial price.
- The Grant will be used to support people who chose to move home in order to live independently. This use of the Grant will secure a better outcome to assess need; represents better value than adaptation; can be used when adaptation of the current home is not practical, and can avoid a more expensive care arrangement (for example, admission to residential care).

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

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

Equality and health inequalities in North Tyneside and CORE20PLUS5

In North Tyneside, the Equally Well Strategy is been 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 ongoing improvement work 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.

- Core20PLUS5 funding has been used to establish health connectors at the social care ‘front door’ team Gateway. These staff support residents with complex and multiple needs associated with drug and alcohol use and/or mental health issues to access health care.

- A Welfare Assistance team is established within the social care front door which provides signposting and funding to individuals in financial distress. This impacts on many of the wider determinants of health by helping to

maintain tenancies/housing, keep homes warm and support nutrition with the provision of support via the food bank.

- 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.

- 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 specifically targeted at harder to reach residents. 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.

- Care and connect is a service that sits within the social care front door and offers advice, information and guidance to enable people to be independent and either remain or become connected with their communities. The team has detailed knowledge of not only the local care and support system but also information about what universal services and recreational opportunities are available in local communities. They work with people to set up new community groups with specialist interest and organise community events to bring people together. The team identify when a person may need additional support and provide help to access a wellbeing assessment. This service is based in Wallsend and specifically targets harder to reach residents who require additional support to access services and who may be socially isolated.

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

Figure 5: Age bands of clients receiving reablement

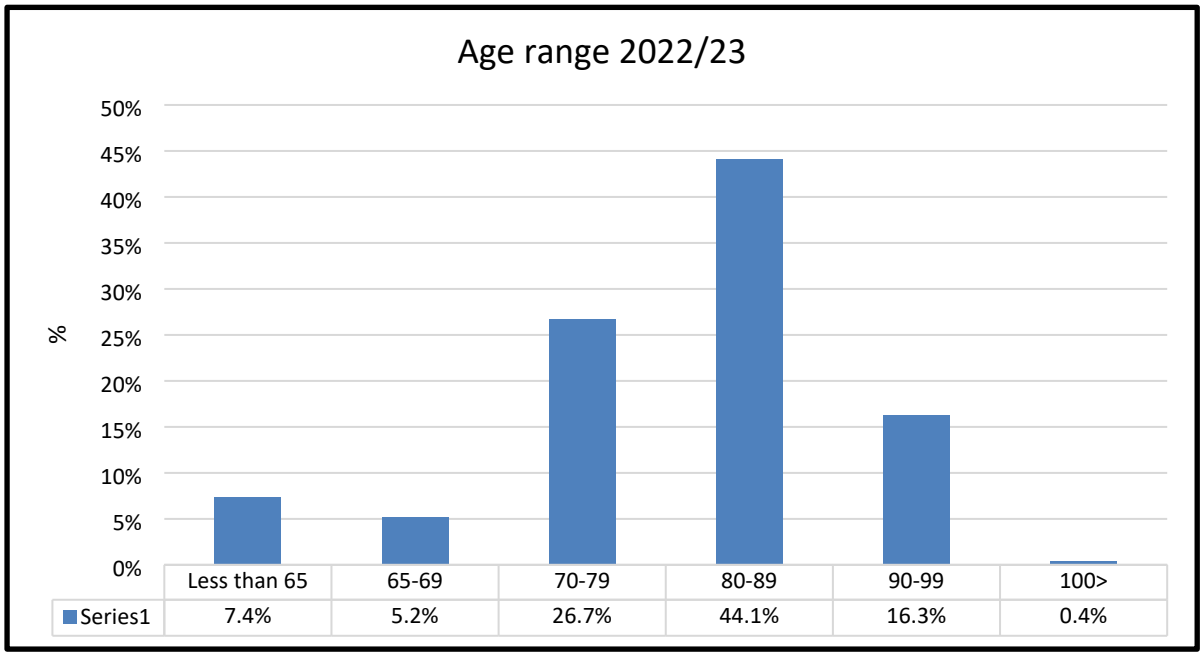


Figure 6 below shows that ethnic minority patients are slightly more likely than white patients to be discharged from hospital to their usual place of residence.

Figure 6: Percentage of hospital patients who are discharged to their usual place of residence, by ethnic origin. Source: NHS Digital BCF Data Pack v2

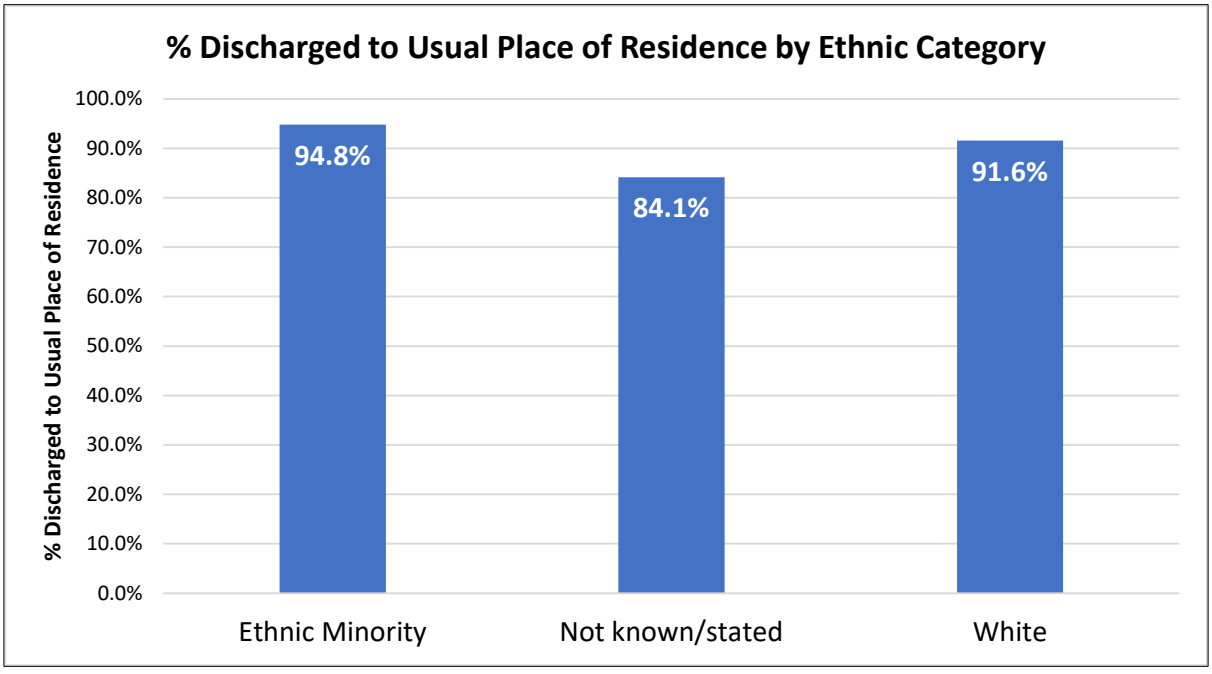
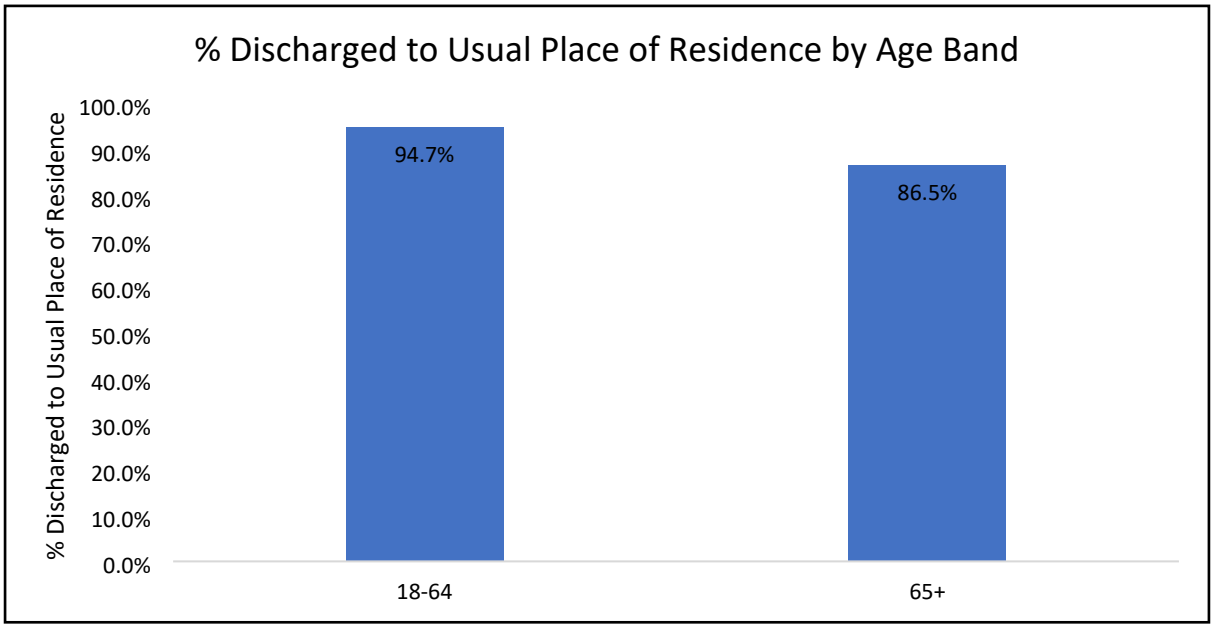


Figure 7 shows that the probability of being discharged to usual place of residence declines with age. The majority of our BCF services are focused on older people in response to the growing levels of need in the older age groups.

Figure 7: Percentage of hospital patients discharged to their usual place of residence. by age bands. Source: Secondary Uses Service



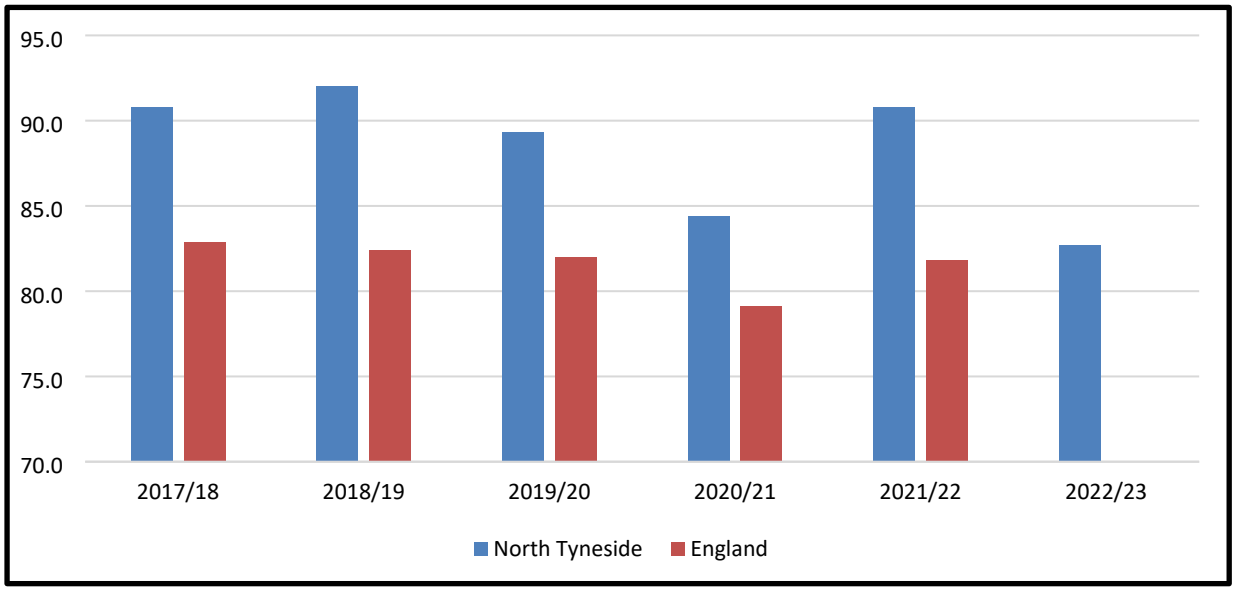
Appendix 1 - BCF Metrics

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 8 below shows that North Tyneside has consistently performed on this metric well above the England average. Locally and nationally, performance was impacted by the COVID-19 pandemic in 2020/21; the North Tyneside rate reduced to 84.4% but remained above the England average. Performance in 2021/22 was 90.8% returning to pre-Pandemic levels and was well above the England average of 81.8% however performance has dropped in 2022/23 to 82.7% as a result of a higher than usual number of deaths and admissions to residential care. This result reflected the general deterioration in condition of the clients being referred into the service. We have reduced the target for 2023/24 to 85.0% while ongoing work progresses to establish whether there has been a longer term shift in the condition of clients entering the service. The service has undergone restructuring to provide an optimum skill mix and provide career development opportunities for staff to progress within the service.

Figure 8: Effectiveness of reablement metric, time series

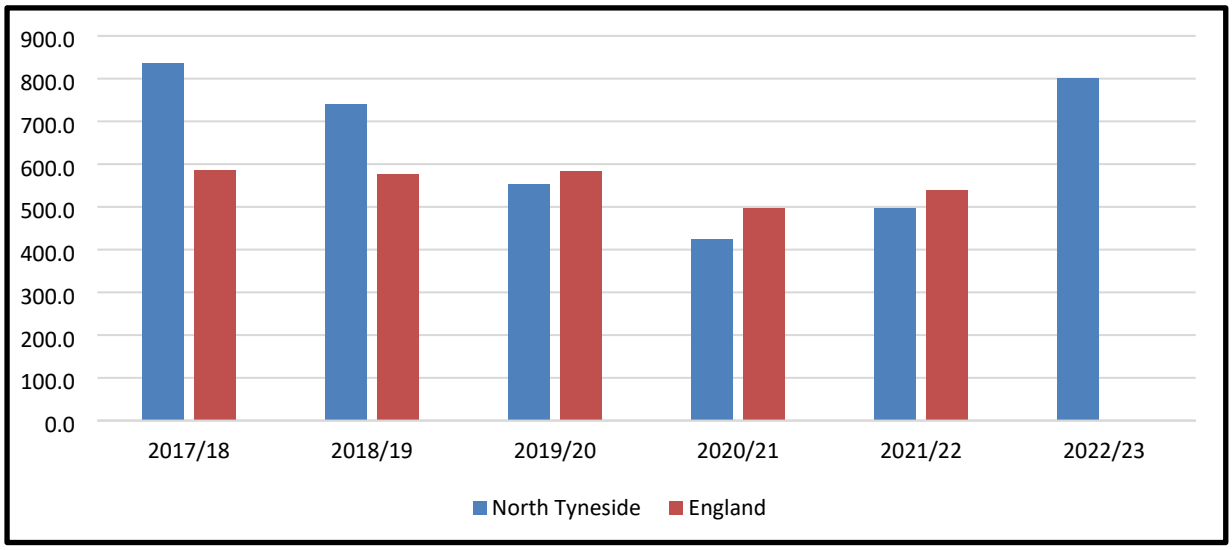


2 Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

Figure 9 shows that North Tyneside has historically had a greater than average reliance on permanent residential care for older people but this reduced to below the England average in each of the last three financial years. In 2020/21 and 2021/22, the outturn was influenced by the COVID-19 pandemic and shortages of capacity in homecare resulting from workforce recruitment and retention issues, which led to a greater proportion of patients being discharged from hospital into short term residential care, funded for a period through the NHS post-discharge funding arrangements. A significant proportion of these short term placements have now become long term and

are counted within this metric. The shortages in homecare capacity have continued in 2022/23 as has the pressure to maintain hospital flow by facilitating efficient discharges. This, combined with a generally more complex cohort of people being discharged from hospital, has lead to a further increase in use of residential care

Figure 9: Time series of permanent admissions to residential care for persons aged 65+, per 100,000 population aged 65+



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

BCF services will impact this goal through:

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

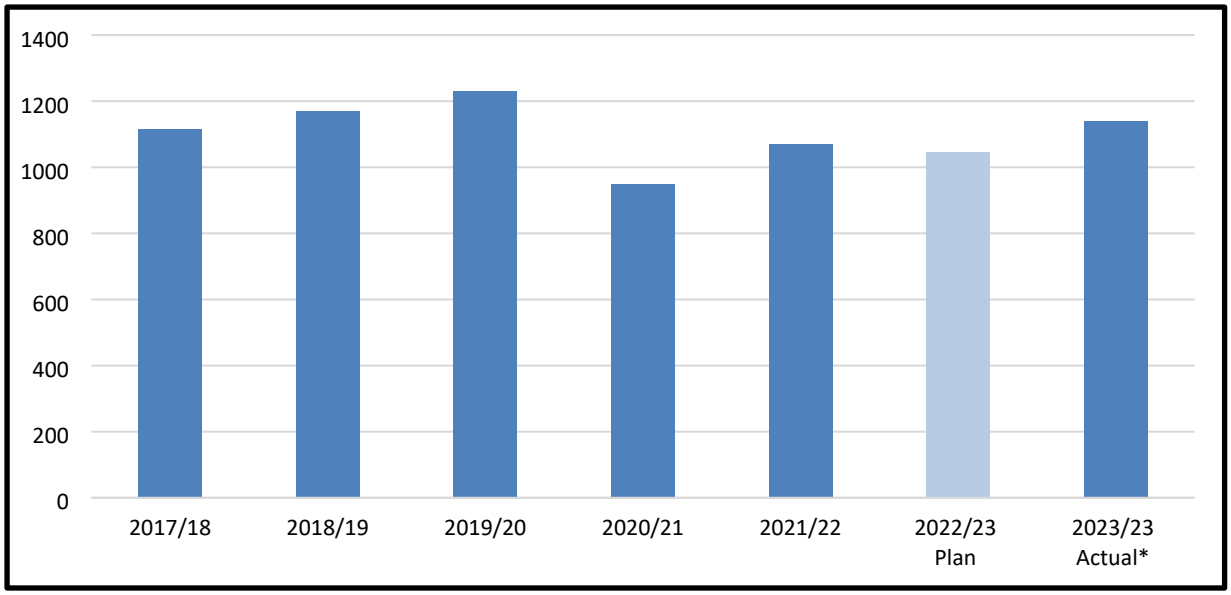
Other developments, not part of the BCF scope, will impact as follows:

- There are 11 extra care schemes across North Tyneside with 479 apartments. Most of these are rental but a small number are shared ownership. Extra care offers individuals the ability to continue to live in the community, at home and have access to on-site care and support through a 24/7 commissioned care team. All apartments are self-contained and individuals are supported to maximise the maintain their independence.
- Further details on the action plan the Local Authority has developed to improve capacity in community based care provision are outlined from p12 of this plan

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

Figure 10 below shows a time-series of unplanned hospitalisation for chronic ambulatory care sensitive conditions, expressed as an indirectly standardised rate per 100,000 people. In 2022/23 North Tyneside's estimated outturn performance of 1139 was 9% short of the target of 1044.

Figure 10: Standardised admission rate of chronic ambulatory care sensitive conditions



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

BCF services will impact this goal by:

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

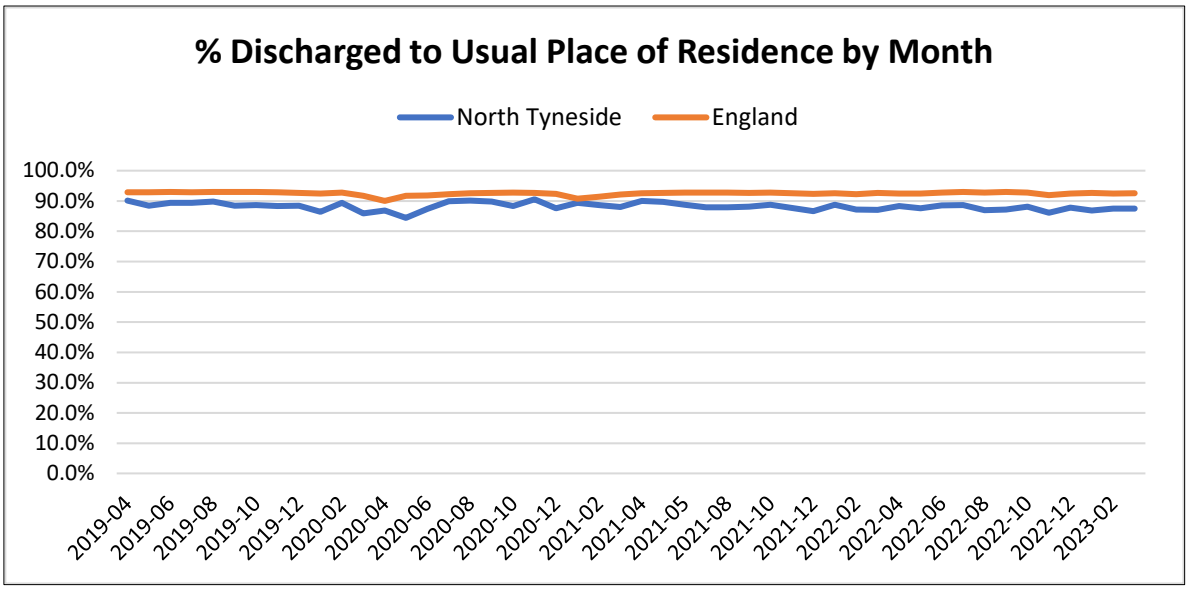
Other developments, not part of the BCF scope, will impact as follows:

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

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

Figure 11 below shows the proportion of people discharged to their normal place of residence from April 2019 to March 2023. The rate for North Tyneside was below the England average throughout the period, by an average of approximately 4%.

Figure 11: % discharged to usual place of residence, North Tyneside compared to England



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

BCF services will impact this goal by:

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

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

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

There was an improvement between 2021/22 and 2022/23 despite residents presenting later with more complex needs. We are aiming to maintain the performance in 2022/23 as the continuing increased presentation of clients who are deconditioned, more frail and more prone to falling.

Figure 12: Trend in Falls admission rates for 65+

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

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

Appendix 2 – BCF services and expenditure

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

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

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