North Tyneside Health and Wellbeing Board

Better Care Fund Plan 2021-2022

Executive Summary

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

The plan provides for a range of investments in:

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

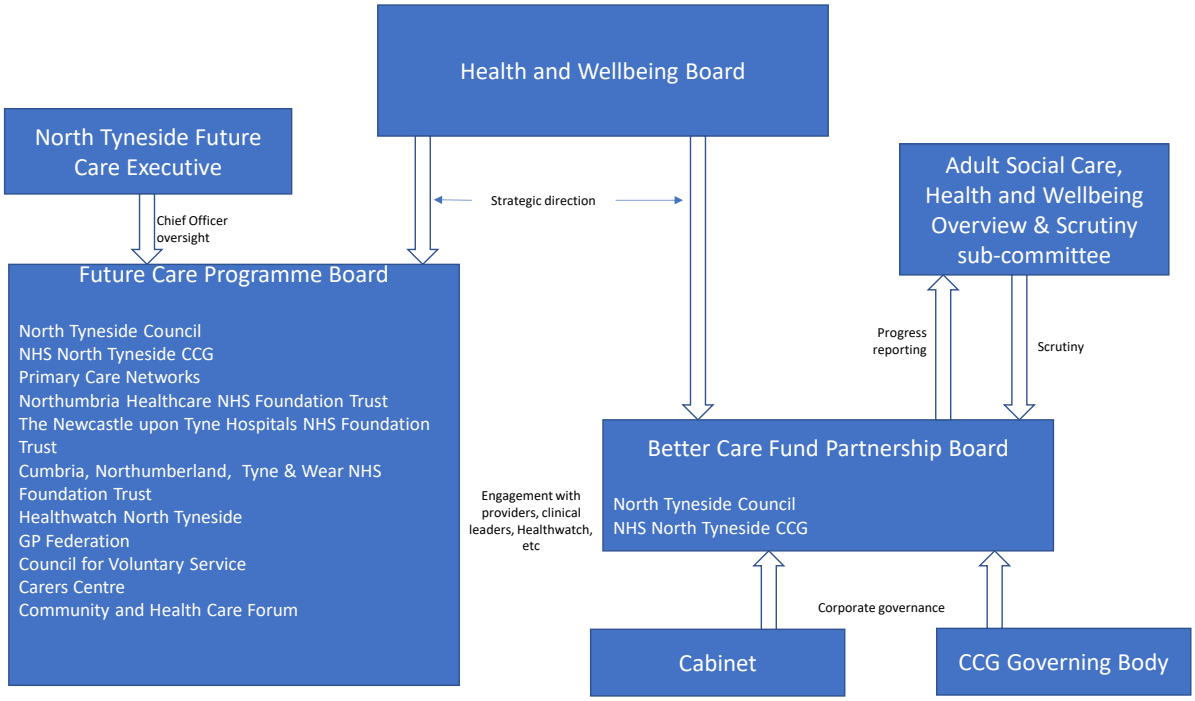
The Improved Better Care Fund element will be used to support the social care market, including meeting the costs of paying the Living Wage to staff in care homes and home care. These investments also support hospital capacity by helping to ensure that discharge services are sufficient to meet demand.

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

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

Governance

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



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

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

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

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

Overall approach to integration

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

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

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

The Local Authority and the Clinical Commissioning Group work collaboratively on a number of initiatives linked to ensuring there are high quality services and support arrangements in place for the people of North Tyneside. More so, over the last 18 months we have seen increasing need for collaboration, joint working and integrated services to meet the health and social care needs of the borough.

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

- The Local Authority leads on the commissioning of nursing placements, shared funding placements in the community and S117 mental health act funded placements for individuals following a detention for assessment and treatment in hospital under the Mental Health Act

- The Local Authority is commissioned by the CCG to undertake continuing health care case management work and to commission CHC placements and packages in the community agreed by the CCG
- The Adaptation and Loan Equipment Service and the Disabled Facilities Grant (both under the Better Care Fund arrangements) put in place services and environmental changes to support people at home
- The work undertaken within the Frailty Pathway Group will deliver on a new Integrated Frailty Service for the borough with integrated provision and services

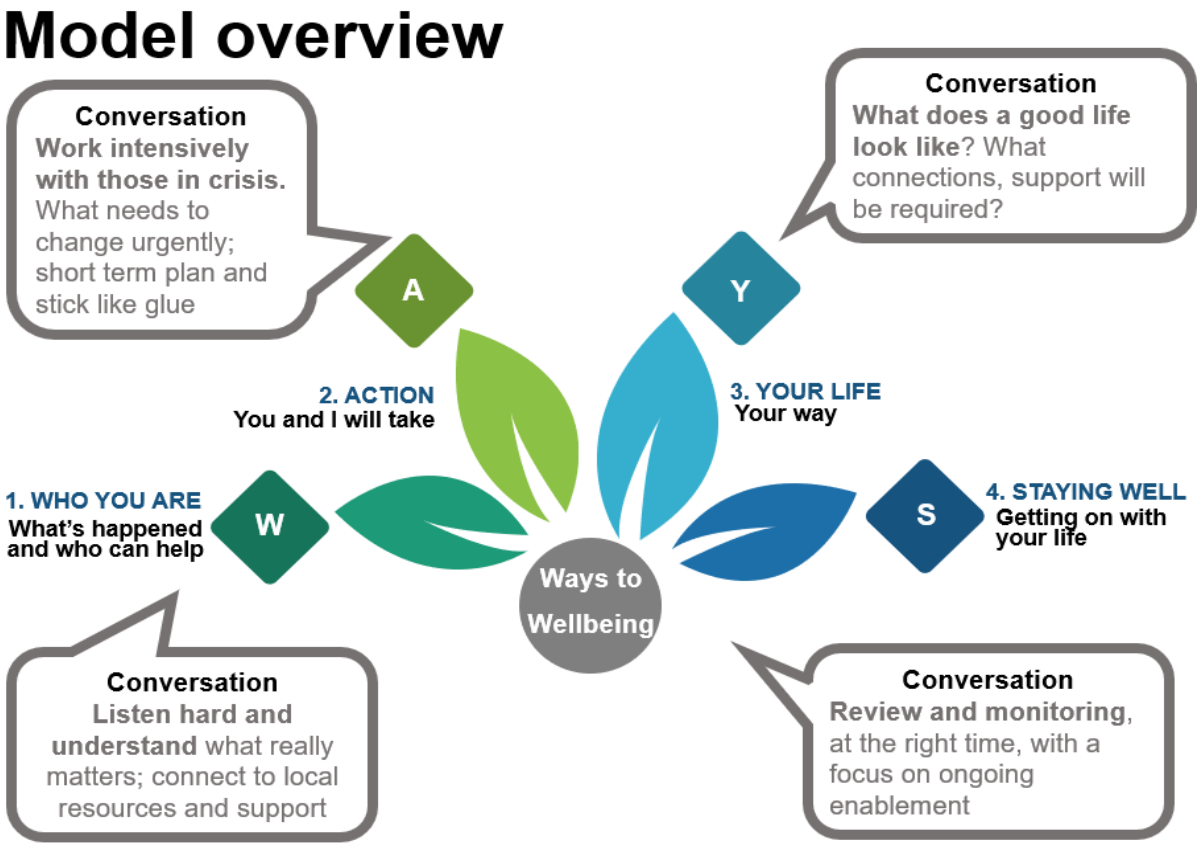
Our use of a strengths-based approach and person-centred care is shown by the development of the “Ways to Wellbeing” model within adult social care. This provides a practice model which

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

The underlying principles of the model are:

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

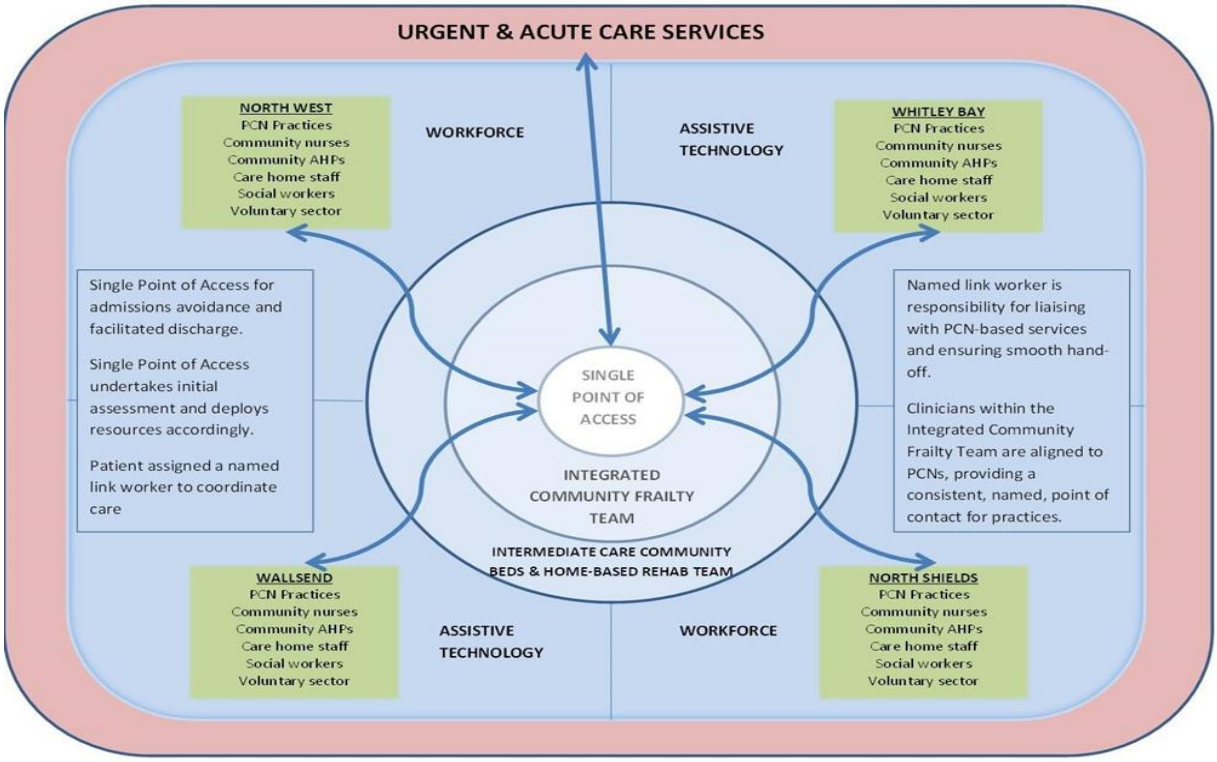
Figure 1: The "ways to wellbeing" practice model



The Integrated Frailty Service

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

- The development of an integrated frailty service within exiting NHS and Local Authority services contracts.
- The development of a new community bed based intermediate care facility at Backworth, which will also house an integrated community frailty / aging well service, bringing together Care Point, Jubilee Day Hospital, and community bed based care under a shared management structure to provide a 'one-stop-shop' for frailty elderly patients. It is expected that, subject to planning permission and procurement processes, building will commence in Q1, and complete in Q4, of 2022.
- A cohort of 17 Community Care Practitioners have been recruited to work in the service and will complete a university programme in April 2022.



The key components of the planned model are:

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

Single point of access

The single point of access will:

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

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

Integrated community frailty team

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

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

To provide:

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

Intermediate care community beds and reablement

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

- Creation of a new community-based facility capable of housing the Single Point of Access and the Integrated Community Frailty Team alongside the intermediate care beds.
- Creation of step-up community bed pathways to support admission avoidance and functions of the SPA.

- Strengthening the role of the peripatetic service.
- Enhancing the role of Personal Independence Coordinator workers and volunteers

Integration with Primary Care Networks and community services

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

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

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

Other BCF services

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

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

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

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

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

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

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

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

Supporting Hospital Discharge

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

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

BCF also funds:

- the *Adaptations and Loan Equipment Service* to ensure that people have equipment that they need to recover at home following discharge, as well as to avoid admission.
- The *Care Call crisis response team* which provides telecare services to help avoid admission and maintain independence following hospital discharge.
- *Enhanced Health Care in Care Homes* helps to support patients who are discharged to a care home, including avoiding re-admission.

Disabled Facilities Grant (DFG)

The DFG aims to:

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

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

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

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

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

Equality and health inequalities

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

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

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

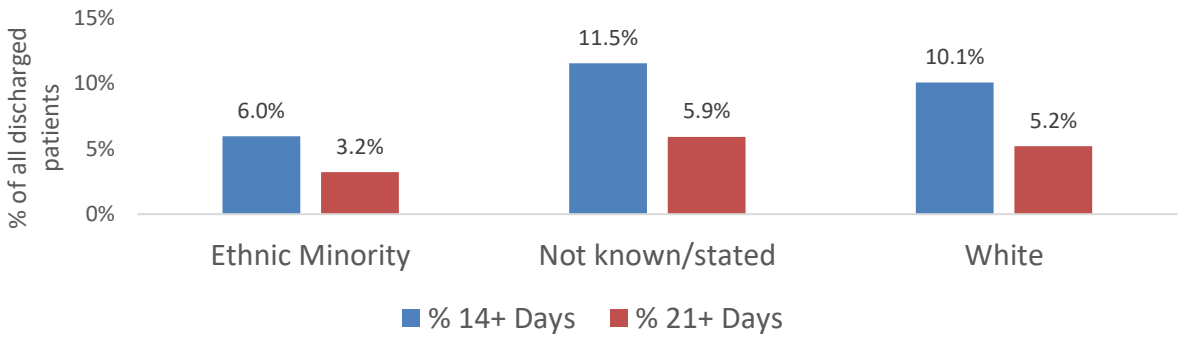
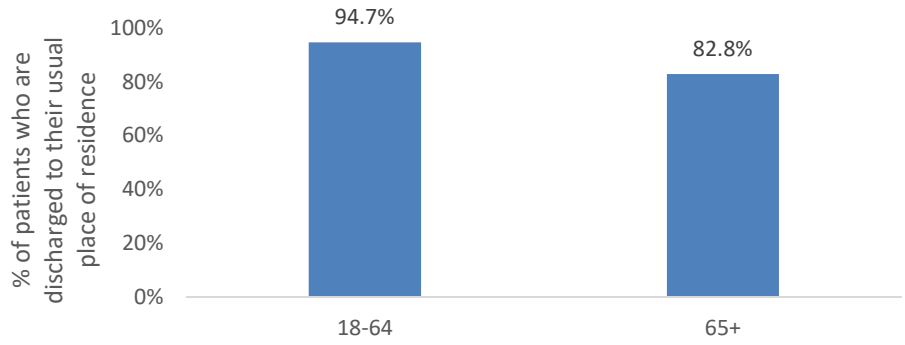


Figure 3 below shows that ethnic minority patients are very slightly less likely than white patients to be discharged from hospital to their usual place of residence.

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

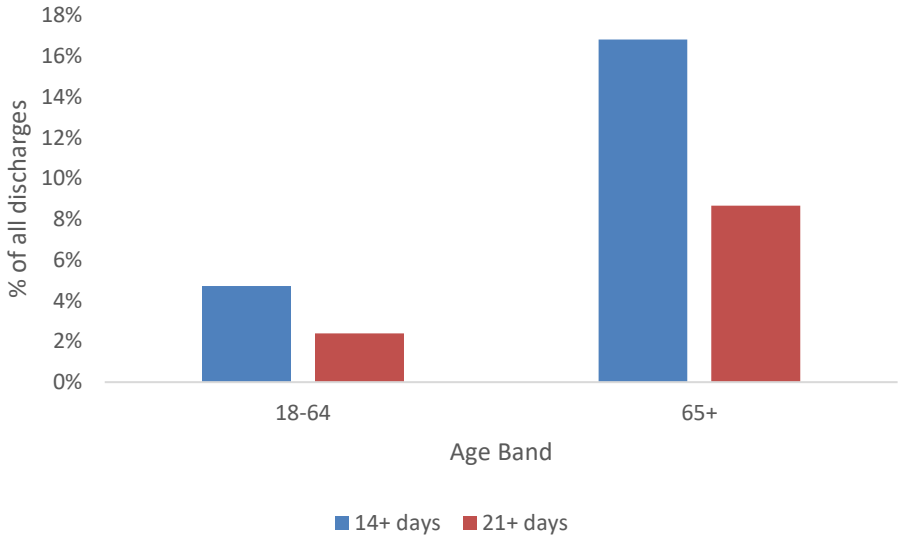
Figure 4 shows that the probability of being discharged to usual place of residence declines with age. The majority of our BCF services are focused on older people in response to the growing levels of need in the older age groups.

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



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

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



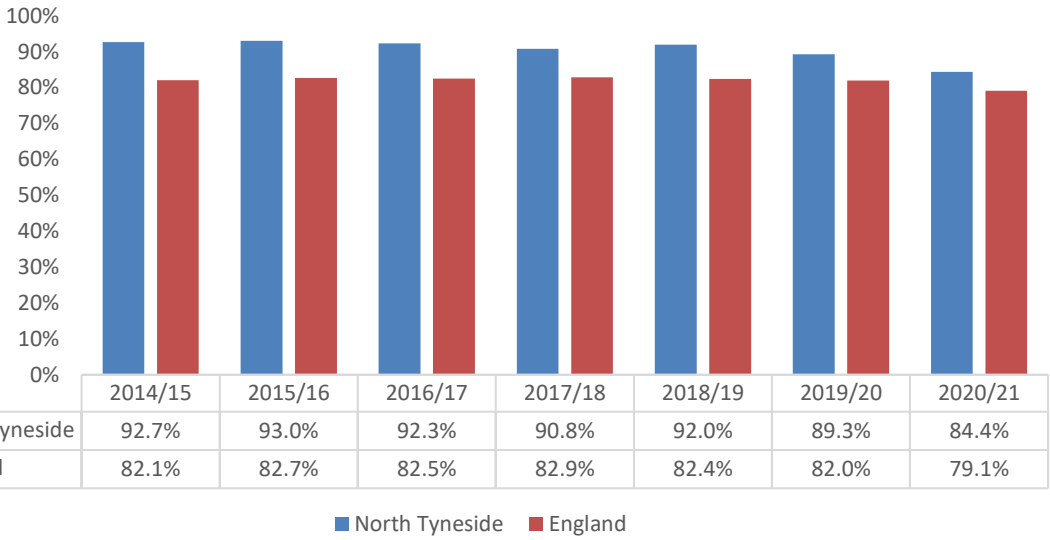
Appendix 1 - BCF Metrics

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

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

Figure 6 below shows that North Tyneside has consistently performed on this metric well above the England average. Locally and nationally, performance was impacted by the COVID-19 pandemic in 2020/21; the North Tyneside rate reduced to 84.4% but remained above the England average. We expect to maintain performance at 85% in 2021/22.

Figure 6: Effectiveness of reablement metric, time series

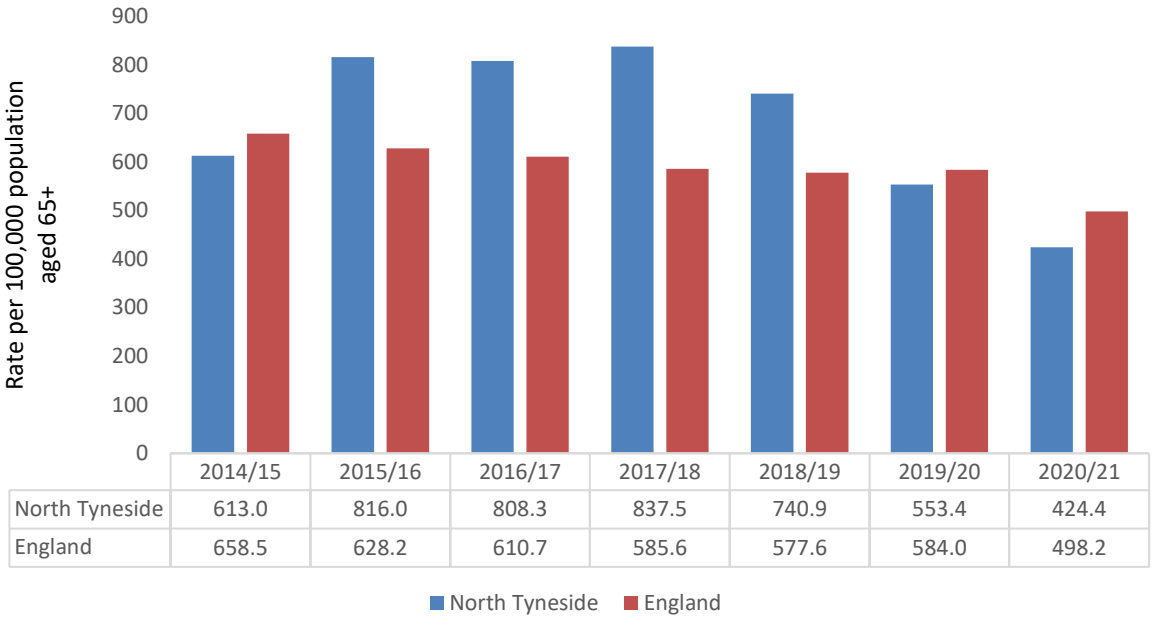


	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
North Tyneside	92.7%	93.0%	92.3%	90.8%	92.0%	89.3%	84.4%
England	82.1%	82.7%	82.5%	82.9%	82.4%	82.0%	79.1%

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

Figure 7 shows that North Tyneside has historically had a greater than average reliance on permanent residential care for older people but this reduced to below the England average in each of the last two financial years. In 2020/21, expect the outturn was influenced by the COVID-19 pandemic, which led to a greater proportion of patients being discharged from hospital into short term residential care, funded for a period through the NHS post-discharge funding arrangements.

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



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

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

BCF services will impact this goal through:

- The continued operation of the CarePoint service, promoting a Home First response to hospital discharges, and it's development as an element of the Integrated Frailty Service
- The provision of the Adaptations and Loan Equipment Service, which helps people to maintain their independence at home.

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

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

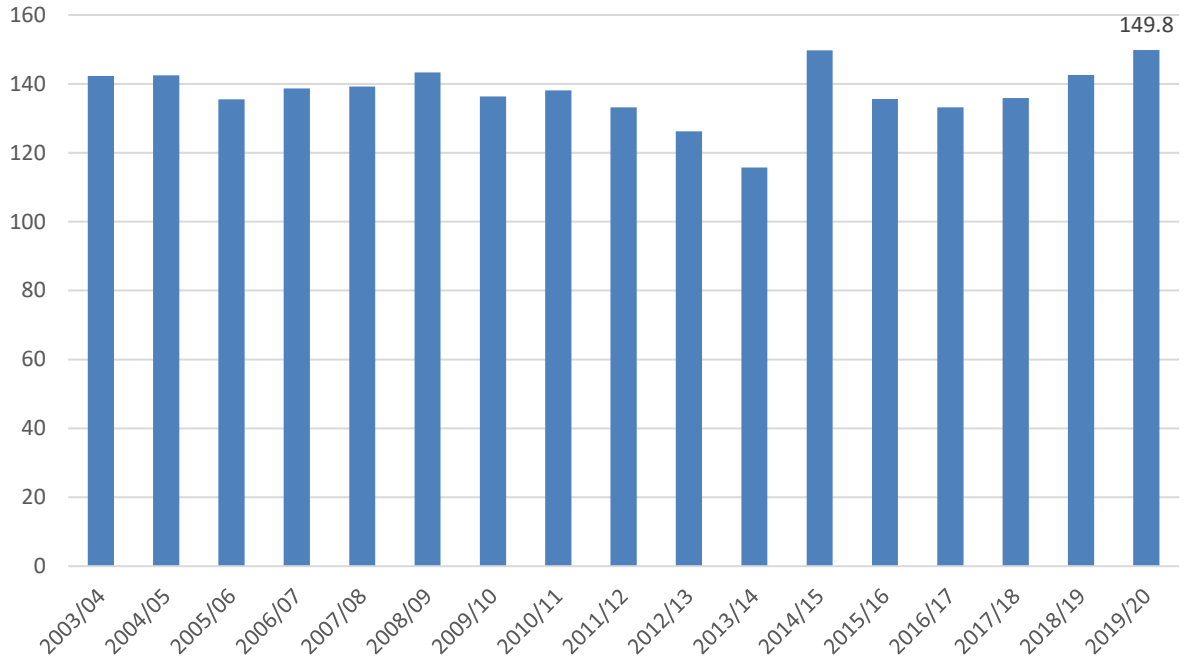
- There are plans for a further two extra care schemes with 104 apartments to come on stream by 31 March 2022. One of these schemes with 40 beds will be dementia specific and will offer a real alternative to a placement in a care home.

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

Figure 8 below shows a time-series of unplanned hospitalisation for chronic ambulatory care sensitive conditions, expressed as a standardised ratio where the England rate = 100. For example, in 2019/20 the North Tyneside rate was almost

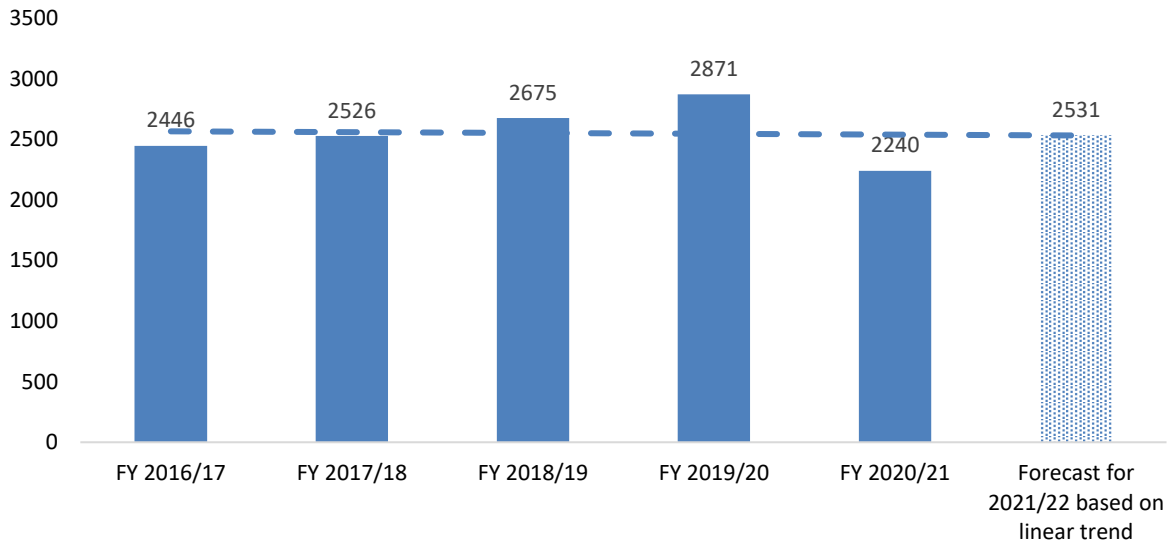
50% higher than the England rate, after taking into account any differences in the age structure of the population.

Figure 8: Standardised ratio of chronic ambulatory care sensitive conditions



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

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



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

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

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

BCF services will impact this goal by:

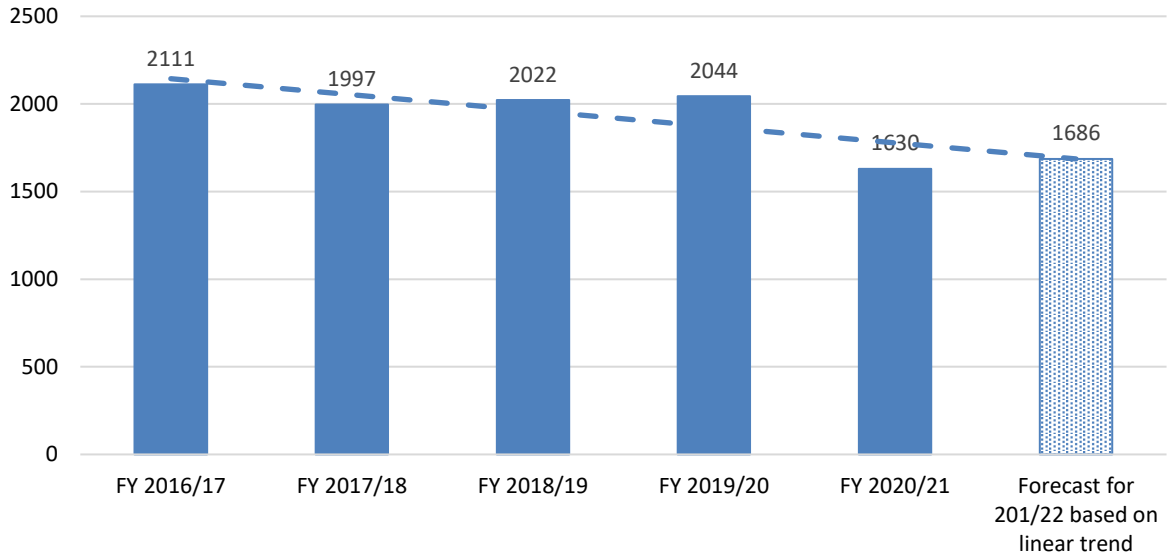
- The Enhanced Care in Care Homes service improves the planning and delivery of healthcare for care home residents, maintains and enhances the quality of care, and increases the number of healthcare interventions that are carried out in a care home setting, hence reducing the number of unplanned admissions to secondary care from nursing and residential care homes.
- The provision of support to carers reduces the number of cases where carer breakdown results in an unplanned hospital admission.
- The provision of high quality discharge planning by CarePoint (an element of the Ageing Well service) reduces the probability of readmission following a sub-obtimal discharge.

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

- The increasing use of a Same Day Emergency Care (SDEC) approach – also known as ambulatory care - is a key component of the approach to reducing unplanned admissions. It aims to minimise and remove delays in the patient pathway allowing services to process emergency patients within the same day as an alternative to hospital admission
- Our urgent and emergency care action plan notes that a number of projects are being put in place to improve hospital flow and discharge, including a review of the current Same Day Emergency Care clinical models to identify opportunities to increase or expand SDEC where appropriate.
- The method of recording Same Day Emergency Care is not standardised across the country, so some Trusts record these cases as inpatients, and some as outpatients. When SDEC are excluded from SUS data, the number of true admissions related to chronic ambulatory care sensitive conditions is shown to be lower than suggested by national data (see Figure 10)

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

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



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

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

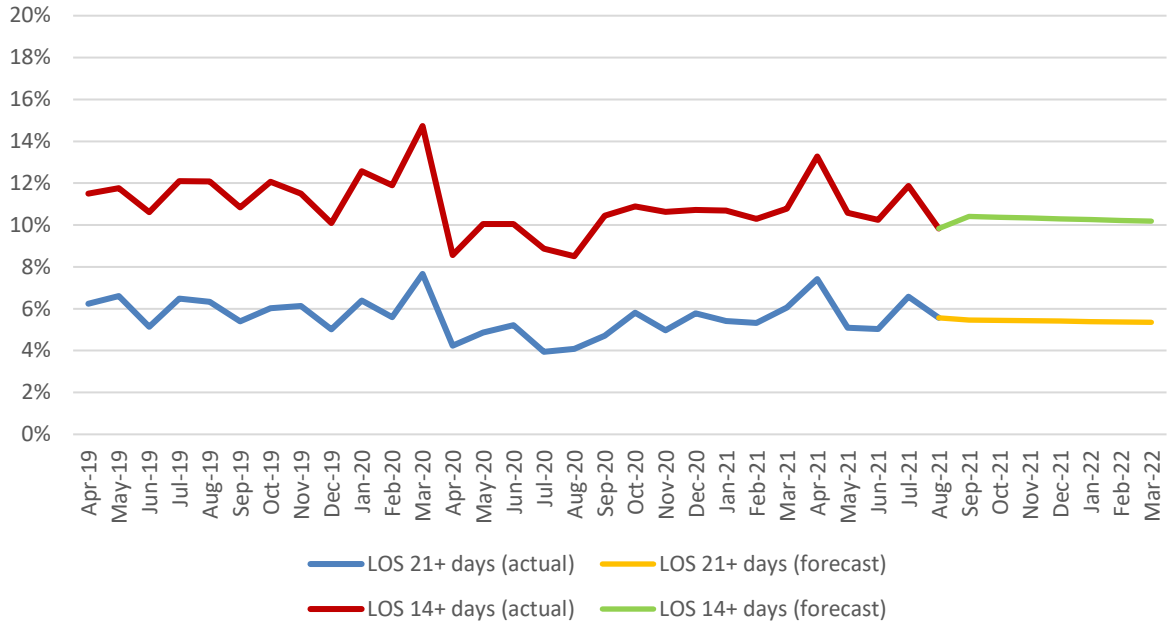
As a percentage of all inpatients

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

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

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

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



BCF services will impact this goal by:

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

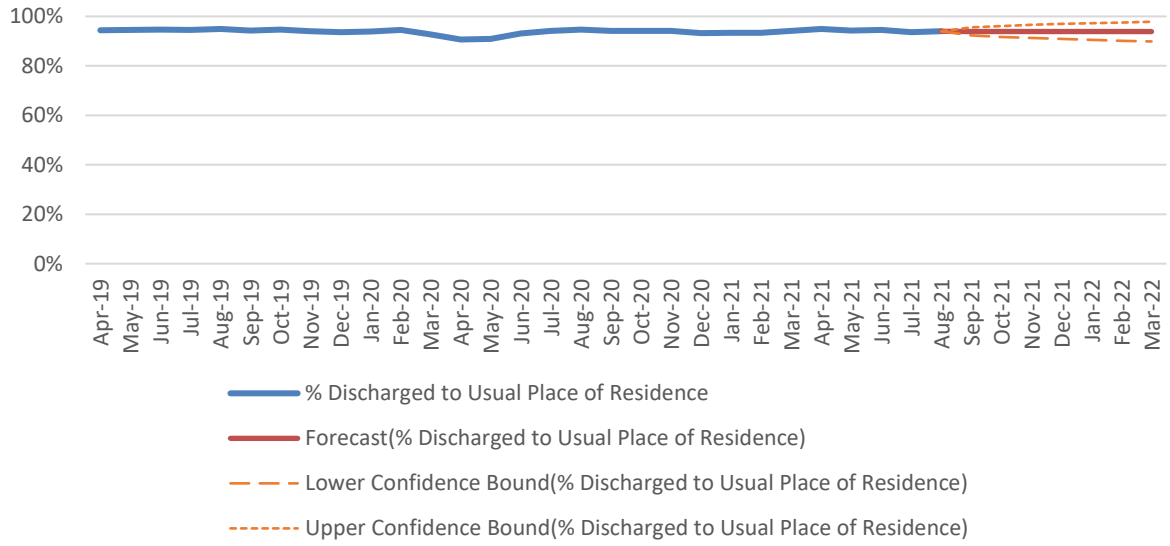
Other developments, not part of the BCF scope, will impact as follows:

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

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

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

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



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

BCF services will impact this goal by:

- The continued operation of the CarePoint service, promoting a Home First response to hospital discharges, and it's development as an element of the Integrated Frailty Service
- The provision of the Adaptations and Loan Equipment Service, and the use of the Disabled Facilities Grant, which helps people to maintain their independence at home.

Appendix 2 – BCF services and expenditure

Scheme ID	Scheme Name	Brief Description of Scheme	Area of Spend	Source of Funding	Expenditure (£)
1	Community--based support	Includes Carepoint; reablement; immediate response and overnight home care; adaptations and loan equipment service; CareCall/telecare; and seven-day social work	Social Care	Minimum CCG Contribution	8,478,578
27	Community-based support	Health contribution to CarePoint	Community Health	Minimum CCG Contribution	1,586,470
2	Intermediate Care beds	Intermediate Care	Community Health	Minimum CCG Contribution	2,984,418
3	Intermediate Care - Community Services	Community Rehabilitation Team	Social Care	Minimum CCG Contribution	863,000
4	Liaison Psychiatry - Working Age Adults	Liaison Psychiatry - Working Age Adults	Mental Health	Minimum CCG Contribution	786,361
6	Enhanced Primary Care in Care Homes	Enhanced Primary Care in Care Homes	Primary Care	Minimum CCG Contribution	1,032,301
19	End of Life Care - RAPID	End of Life Care	Community Health	Minimum CCG Contribution	250,488
8	Improving access to advice and information	MyCare and Living Well in North Tyneside digital services	Social Care	Minimum CCG Contribution	36,148
9	Care Act implementation	Care Act implementation	Social Care	Minimum CCG Contribution	739,097
10	Carers Support	Carers Support	Social Care	Minimum CCG Contribution	671,000
12	Independent Support for People with Learning Disabilities	Independent Support for People with Learning Disabilities	Social Care	Minimum CCG Contribution	718,928
25	Community Falls First Responder Service	Avoiding unnecessary paramedic response to falls at home	Social Care	Minimum CCG Contribution	144,399

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