AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

27th April 2022

REPORT OF DIRECTOR OF ADULTS AND HEALTH

STOCKTON-ON-TEES BETTER CARE FUND (BCF) UPDATE

Stockton-on-Tees BCF 2022/23

SUMMARY

The purpose of this paper is to provide the Health and Wellbeing Board with an overview of the Stockton-on-Tees BCF and the latest performance against BCF metrics 2021/22

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Note the overview of the Stockton-on-Tees Better Care Fund
2. Note the BCF 21/22 performance

MAIN REPORT

The vision for the Stockton-on-Tees BCF is to enable people to live at home longer, be healthier and get the right support where required, whether this is provided by health and/or social care. The focus is on integrated health and social care, primary prevention, early diagnosis and intervention and supported self-management, with the aim of closing the health and wellbeing gap and reducing health inequalities.

It also supports other local and regional aims and outcomes including the Ageing Well programme which is a blueprint for attenuating rising health service demand to support older people with frailty in their communities. There is also a focus on maintaining sustainable services with the pressures caused by the on-going covid-19 pandemic.

BCF Metrics

The BCF Policy Framework sets 5 national metrics for the 2021/22 BCF plans. This includes two existing metrics:

- Effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)
- Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population.

The previous metric on non-elective admissions has been replaced with:

- a measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions).

There is an increased emphasis on 'home first' with new metrics introduced to reflect the hospital discharge guidance:

- Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
- Improving the proportion of people discharged home using data on discharge to their usual place of residence.

The table on the next page sets out the performance against each indicator for Stockton-on-Tees.

Four out of the five metrics are on track to achieve the planned performance.

Residential Admissions

- Rolling 12 month position to Dec-21 shows performance rate of 705.1 vs a 21/22 target of 790.2 and therefore on track to achieve.
- The Q3 2021-22 period has seen a lower number of admissions than in previous years. The majority of admissions (88%) continue to be for Residential Care. Nursing Care admissions remain broadly in line with previous periods. Some caution should be taken with admission numbers due to migration to a new case management system from September 2021. Although data quality checks are in place there is some impact from legacy records that are not reportable in the new system.

Re-ablement

- The Quarter 3 position shows performance of 85.4% against a target of 86.0% therefore slightly behind plan.

Length of Stay

- The plan for Q3 and Q4 was to maintain the 20-21 performance against both indicators which was already well below the national average. Q3 actual performance against both indicators is below the plans set. Percentage of patients with a hospital length of stay over 14 days 7.9% and 3.4% over 21 days.

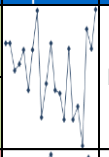
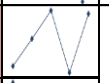
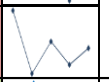
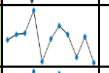
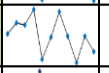
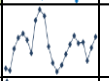
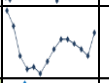
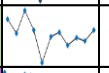
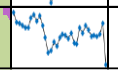
Home First – Discharge to Normal Place of Residence

- The 21-22 plan of 93.3% was a 0.3% improvement on published data for 20-21. This ambition was met in Q1 (93.3%) and again in most recently reported data for Q3 (93.7%) but did fall slightly below in Q2 (93.1%). Overall, for the year this ambition is being achieved.

Avoidable Admissions

- This indicator is monitored on an indirectly standardised rate, calculated by looking at the number of admissions, versus population and then standardised. The impact of Covid-19 has significantly impacted on this indicator and therefore it was difficult to accurately predict expected demand over Q3 and Q4 of 2021/22.
- The rolling 12-month position against this indicator to Dec-21 shows performance of 1,065.9 versus a target of 1,103.1 and therefore achieving the target set.

The table below summarises the latest position for each indicator.

Stockton-on-Tees			2020/21 (unless otherwise advised)			2020/21	2021/22	2021/22 (unless otherwise advised)					
Indicator			Actual	Plan	Variance	Plan	Plan	Period	Actual	Plan	Variance	Sparkline	Data Points
Residential Admissions	Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population		619.8	N/A	-	N/A	790.2	Latest 12 month rolling	705.1	790.2	-85.1		Monthly Rate
			229	N/A	-	N/A	297		265	297	-32		
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (effectiveness of the service)		86.3	N/A	-	N/A	86.0	Q3 2021/22 (Q3 / Q2)	85.4	86.0	-0.6		Quarterly
			44	N/A	-	N/A	129		41	129	-88		
LOS 14+ Days	Length of Stay (LOS): 14 Days and Over		8.7%	N/A	-	N/A	Q3=8.7% Q4=8.7%	Q3 2021/22	7.5%	Q3=8.7% Q4=8.7%	1.2%		Quarterly
LOS 21+ Days	Length of Stay (LOS): 21 Days and Over		4.0%	N/A	-	N/A	Q3=4.0% Q4=4.0%	Q3 2021/22	3.4%	Q3=4.0% Q4=4.0%	0.6%		Quarterly
Stranded Patients	Average % of beds occupied by Stranded Patients		41.8%					2020/21 (Jan)	40.4%	N/A			Monthly
	Average % of beds occupied by Super Stranded Patients		10.3%						10.8%	N/A			Monthly
Normal Place of Residence	Discharge to Normal Place of Residence		93.0%	N/A	-	N/A	93.3%	Q3 2021/22	93.7%	93.3%	+0.4%		Quarterly
ACS Admissions	Unplanned Admissions for Chronic Ambulatory Sensitive Conditions		965.9	N/A	-	N/A	1103.1	Latest 12 month rolling	1065.9	1103.1	37.2		Monthly numerator

BCF Funded schemes and services

Building on the successes of previous years, the Stockton-on-Tees BCF continues to support further integration and partnership working that delivers improved outcomes for older people. It has funded schemes and services to increase accessibility and improve integrated care through early assessment, intervention and prevention to avoid unnecessary complications and acute crisis.

Support provided to care homes

Stockton-on-Tees BCF has funded a range of schemes to improve health, wellbeing and safety of people living in care homes. A comprehensive training programme has also been commissioned to upskill the workforce. These schemes include:

Enhanced Health in Care Homes

Community matrons undertake a proactive home round and have monthly multi-disciplinary teams with GP, pharmacy and nursing input as a minimal to support personalised care planning, alongside the care home nursing team.

Dedicated pharmacy support has been commissioned via BCF to drive quality regarding medicine management, policies and the implementation of proxy medication ordering for all care homes.

A digital programme of support has been commissioned to enhance and support the delivery of digital developments in care homes to support delivery of:

- NHS Mail
- Proxy ordering of medication
- Personalised care and support planning
- Information sharing

Care Home Training and Education Programme

The programme is a collaboration between SBC, the North Tees and Hartlepool NHS Foundation Trust, and the Tees, Esk and Wear Valleys NHS Foundation Trust to provide training for care home staff. The programme includes:

- End of life
- Dementia and delirium awareness
- Falls awareness
- Pressure damage and skin integrity
- Recognising deterioration
- Respiratory training
- Oral health for care home setting
- A digital element to the service which is the implementation of the NEWS monitoring system. NEWS has also been implemented into all Stockton care homes.

Falls Monitoring in Care Homes Project

The project is delivered by SBC OneCall Service to provide occupant exit sensors to care home residents who have cognitive impairment and are at high risk of falling. It has continued to provide early support which is one of the key interventions for residents in care homes to manage avoidable falls and subsequent secondary healthcare. The project has provided additional benefit during the pandemic by reducing unnecessary exposure and contact between staff and residents who were isolating.

Intensive Community Liaison Service

Provided by Tees, Esk and Wear Valley Mental Health NHS Trust, the aim of the service is to provide early assessment and intervention for people living with dementia, supporting them to live well for as long as possible and minimise the risk of unplanned hospital admissions. An Emergency Health Care Plan is created to help the person with dementia and their carers to manage their conditions and care home staff to use proactive thinking on specific management and strategies to prevent hospital admission. The service also provides education and support to care homes and community staff to raise awareness of dementia and delirium.

Supporting discharge from hospital

Stockton-on-Tees BCF funds services to deliver an integrated system where Health and Social Care work together to put the patient at the heart of everything they do. Integrated working improves people's health outcome as more people will be able to live at home for longer and they can access urgent care at the time they need it. These schemes and services include:

Rapid Response Front of House

A Rapid Response Nurse is funded as part of the Home First Service at the front of house in the North Tees and Hartlepool NHS Foundation Trust as part of the Home First offer alongside therapy staff and the Frailty Coordinators.

Integrated Single Point of Access (iSPA)

iSPA is an integrated single point of access across North Tees & Hartlepool NHS Trust and Stockton-on-Tees Borough Council. It provides a multi professional triage and care plan development service to improve pathway access and delivery for health, social and VCSE services ensuring people get access to the right early help and specialist support. The main purpose of the iSPA is to bring together expertise across organisations to strengthen information sharing, risk assessment and joint decision making to ensure people and their families receive the right services at the right time.

Clinical Triage

A joint Health and Social Care initiative focusing on supporting people coming out of hospital who may have ongoing needs. It has been continued to support wider transformation plans for intermediate care/new models of care.

Community Integrated Intermediate Care (CIIC)

The CIIC service provides a range of functions including crisis response services to prevent a person going into hospital, rehabilitation and reablement which enables people to regain their independence and remain, or return to, their own homes. Through improvement in coordination of care across health and adult social care, the CIIC service is providing:

- an integrated health and adult social care assessment
- a service offer which that is available 7 days a week
- efficiencies as services work more effectively when both volume and activity and the breadth of services are available across the system

Following the peak of COVID, the Community Integrated Assessment Team (CIAT) within the CIIC is experiencing an increase in referrals due to the demand on community services to prevent hospital admission, to support timely hospital discharges, and most importantly to improve quality of life following a year of isolation and reduced mobility for many patients. Funding has since been approved to increase capacity in CIAT to support patients with complex needs and high acuity in the community.

Rosedale Centre

The Rosedale Centre is a 365 day / 24-hour service, 44 bed facility with a focus on short term residential rehabilitation and assessment. It is used by both Health and Social Care as an intermediate care facility to enable:

- a social care assessment of support needs to be undertaken at which point a review is undertaken and appropriate care planning determined. Patients are admitted from either hospital of the community. The overall stay is normally up to 6 weeks as the Care Plan, setting out support needs, is put in place to enable a patient's safe return to a home environment.

- a rehabilitation service primarily to support a patient's physical rehabilitation on discharge from hospital where intermediate care support is required prior to them returning home. NTHFT have a team based at The Rosedale Centre who assess and deliver physiotherapy support. Care planning, by Social Workers, is also integral to the patient's overall well-being in preparation for their return "home". The overall stay is up to 6 weeks.

A Community Matron is funded to provide clinical response to patients who are receiving support/care within the Rosedale Centre.

Frailty coordinator

Working front of house in A&E, the Frailty Coordinators coordinate the care of patients and lead the decision-making process with the aim of avoiding unnecessary hospital admissions. They have comprehensive knowledge of the services available to patients in the community and the ability to initiate an early referral into these.

When a frail patient is admitted, they continue to coordinate the care of the patient for the duration of their stay, to ensure they do not stay in hospital longer than is medically necessary.

Rapid Response Home Care

Stockton-on-Tees BCF has block commissioned 2 domiciliary care providers to provide 2-hour response to support the market, hospital discharge and admission avoidance.

Carers' Support:

Carer Support Service

Stockton Adult Carers Support Service supports carers by empowering them to develop opportunities to explore and promote their own wellbeing and quality of life. This includes promoting the take up of support and carers assessment. The service offers ad hoc respite for carers to have a break from their caring role through the Time Out Support Service and opportunity for carers to connect with each other directly to provide small scale peer support and the development of supportive relationships.

Health inequality

Warm Homes Healthy People Programme

The Warmer Homes Healthy People (WHHP) Programme is a collaboration of partner organisations, managed by SBC to deliver interventions that support affordable warmth and contribute to reducing fuel poverty. It aligns with the BCF objective of reducing pressures on the NHS, including seasonal winter pressures.

Services commissioned from VCSE

Stockton-on-Tees BCF has also funded 2 schemes which are delivered by the VCSE. By working closely with the sector we are able to jointly identify opportunities where they can support the BCF outcomes.

Staying Out

Staying Out is delivery by ARC to engage people aged 65 or over, have chronic health conditions and are leaving hospital, recognised as being at high risk of readmission or identified as being socially isolated. The scheme is a weekly artist-led creative arts activities to keep socially isolated older people active and signpost to other subsidised creative activities within ARC's main programme or other activities and services in the area.

Better Wealth Better Health Scheme

The Scheme is delivered by AgeUK Teesside and aims to improve health and wellbeing and reduce social isolation. Delivery of the programme is in line with NICE guidance: Older people: independence and mental wellbeing, which details the importance of offering services that include one to one and group activities, befriending and welfare advice.

Presentations

There will be two presentations at the Board:

Presentation 1: A person's journey through iSPA, Rosedale, Reablement and Intermediate Care

Presentation2: Clinical Triage, Frailty Coordinator and Care Home Education Programme

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