AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

21st September 2022

REPORT OF: Assistant Director Adult Strategy and Transformation; Head of Commissioning and Strategy North East and North Cumbria Integrated Care Board

STOCKTON-ON-TEES BETTER CARE FUND PLANNING REQUIREMENTS 2022/23

SUMMARY

The purpose of this paper is to seek approval from the Health and Wellbeing Board for the Stockton Better Care Fund Plan 22/23.

RECOMMENDATIONS

That the Stockton-on-Tees Better Care Fund Plan 22/23 submission, be approved.

BACKGROUND

1. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2022-23. The framework forms part of the NHS mandate for 2022-23.
2. The use of BCF mandatory funding streams (NHS minimum contribution, Improved Better Care Fund grant (iBCF) and Disabled Facilities Grant (DFG) must be jointly agreed by integrated care board (ICB) and local authority to reflect local health and care priorities, with plan signed off by Health and Wellbeing Board (HWB). BCF plan should include stretching ambitions for improving outcomes against the national metrics for the fund. No new metrics have been introduced for 2022-23.
3. The two objectives for 2022-23 BCF are:
    i. Enable people to stay well, safe and independent at home for longer.
    ii. ii. Provide the right care in the right place at the right time.
4. National condition four of the BCF has been amended to reflect these two objectives and now requires HWB to agree an approach within the BCF Plan to make progress against these objectives in 2022-23.
5. The draft BCF was sent to the NHS England BCF Team for comment and feedback has been received and is highlighted in yellow of the attached.

DETAIL

6. The Stockton-on-Tees Better Care Fund Plan 22/23 is broken down into two main documents:
   - Planning Requirements Template
   - Stockton-on-Tees Better Care Fund Narratives

Draft submission to NHSE for comment	31st August 2022
Approval from BCF Delivery Group	9th September 2022
Approval from Pooled Budget Partnership Board	12th September 202
Final BCF Planning Requirements submitted signed off by Health and Well-being Boards	21st September 2022

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Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Stockton-on-Tees

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Stockton-on-Tees Better Care Fund (BCF) plans have been developed collectively over the past years through regular meetings between the North East and North Cumbria Integrated Care Board (ICB) and Local Authority commissioners, Pooled Fund managers and BCF leads. It has been agreed that many of the BCF schemes are recurrent 'business as usual' so these will be included in the plan for this and future years.

Linking with the members of these groups, colleagues across the system have the opportunity to present business cases around potential new schemes to address a need or gap identified and which would support the BCF and system priorities and metrics. These are duly considered against what uncommitted funding is available and decisions on whether to approve them are made jointly between the ICB and Local Authority.

Locally, the BCF plan has been jointly developed by partners, specifically:
• North East and North Cumbria Integrated Care Board (ICB)
• Stockton-on-Tees Borough Council (SBC)
• North Tees and Hartlepool NHS Foundation Trust (NTHFT)
• Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)

How have you gone about involving these stakeholders?

Groups involving various stakeholders which have informed BCF Plans include:

- **Hartlepool and Stockton Discharge Group**
- **Community Integrated Intermediate Care Group** – involving partners across Health and Social Care, the group undertook a review of Intermediate Care Services with a view to underpinning the realisation of a number of strategic and operational goals which provided the opportunity to:
  - Improve coordination of care across health and adult social care
  - Provide an integrated health and adult social care assessment
  - Provide a service offer which is equitable across both Hartlepool and Stockton-on-Tees and available 7 days a week
  - Deliver efficiencies as services will work more effectively when both volume and activity and the breadth of services are available across the system

Many of our new schemes this year have been developed to support the Home First/ Discharge agenda. This has involved extensive discussions and planning with colleagues from North Tees and Hartlepool NHS Foundation Trust and other partners for example the care home and domiciliary care sector. The LA, ICB and Foundation Trust engage regularly with the care home and domiciliary care sector via forums and other mechanisms to identify needs, pressures and provide support.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

The vision for the Stockton-on-Tees BCF is to enable everyone to live at home longer, be healthier and get the right support where required, whether this be provided by health and/ or social care. The focus will be 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 as well as driving transformation to close the care and quality gap.

The Stockton-on-Tees iBCF plans will contribute towards:

- Meeting adult social care needs
- Reducing pressures on the NHS through improved patient flow
- Stabilising the social care provider market
- Integration of health and social care services

https://northeastnorthcumbria.nhs.uk/priorities/

The North East & North Cumbria Integrated Care Board's priority, by working with local communities, our partner organisations and our health and care staff, is to significantly improve the health and wellbeing of the people who live in our region and create a health care system which is fit for the future. This includes:

Living Well ~ supporting people to manage their own condition and make the right lifestyle choice

Joining up health and social care – integrate services and provide them around people's needs

Reducing inequalities – addressing the long-standing inequalities and poor health outcomes in our region

The Tees Valley Area of the ICB will be responsible for setting out key priorities and developing our strategy for health and care to meet the needs of our population by bring together local councils, hospitals, community services, primary care, hospices, and voluntary, community and social enterprise (VCSE) organisations and Healthwatch across the region.

The BCF plan supports the local and regional aims and outcomes. Priorities for 2022-23 are aligned to the objectives above and to the BCF and Ageing Well principles. There is also a focus on maintaining sustainable services with the pressures caused by the ongoing Covid19 pandemic, potential impact of flu and the impact of increased hospital discharges following restarting of elective activity across a range of hospital specialisms.

Avoidable Admissions

There is a continued priority on admission avoidance in urgent care situations focussed on ensuring robust assessment, decision making and diversion to more appropriate services and support when needed. There are a range of community services funded by the BCF to support this including additional rapid response, front of house services in the hospital,

the Single Point of Access (SPA) including clinical triage and various schemes to support the care home sector. The Urgent 2-hour community response below will also support achievement of the avoidable admissions metric.

Length of Stay and Discharge to Normal Place of Residence
This has been a focus of joint initiatives and plans this year and most of the changes to our BCF plan this year are to support these outcomes. Health and social care have worked together to develop initiatives to reduce length of stay and discharge people home as quickly and safely as possible. Partners have worked together to agree local discharge arrangements including the use of funding and implementing a Trusted Assessor scheme. Partners across health and social care are working on a solution to continue to support/ fund the discharge pathways going forward.

Residential admissions - *older adults whose long-term care needs are met by admission to residential or nursing care*
The Discharge to Assess initiative along with intermediate care and rapid response services offers the opportunity for people to receive the care and time needed to maximise recovery, maintain independence and avoid admission to long term residential, nursing care and home care whenever possible.

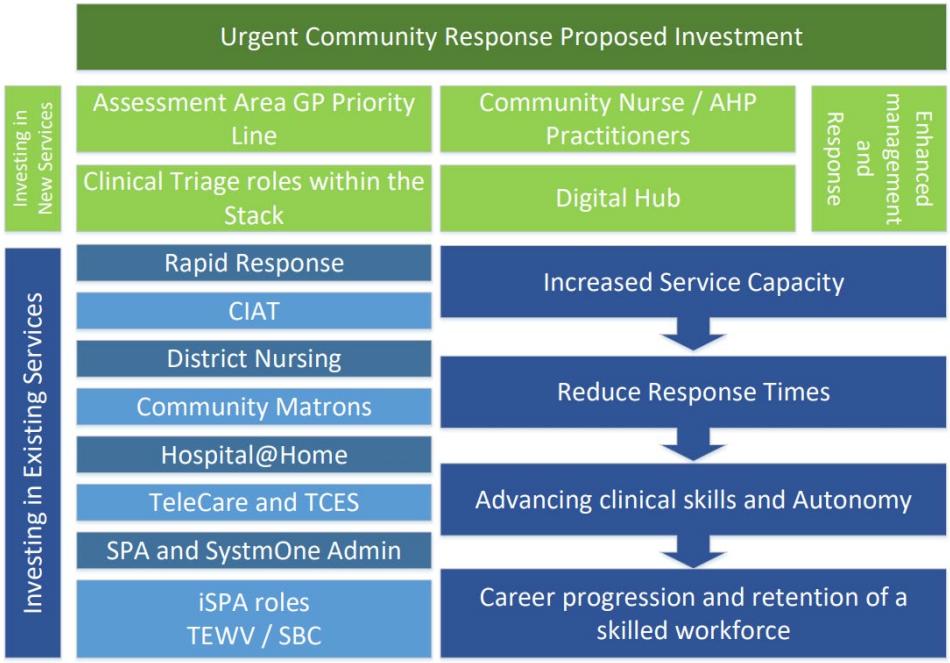
Additionally, positive relationships with providers of both residential care, nursing care and home care services continue to support this work and reduce the number of people accessing long term residential care. A range of community-based services support people to feel safe in their own home and give them confidence to return to the community following a period of rehabilitation.

Effectiveness of Reablement *proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)*
The range of BCF schemes to support reablement will continue and include assistive technology, rapid response, rehabilitation, adaptation, and onward referrals onto VCSE and community services to empower self-management.

Urgent 2-hour community response:
Stockton Borough Council are part of the 'Urgent and Emergency Care Managed Clinical Network' and local 'Tees Valley Urgent Community Response Group.'

Proposals have been submitted to enhance existing services to deliver an ISPA urgent 2 hour response 24/7 across North of Tees. This will be delivered in partnership with South Tees NHSFT, Stockton Borough Council, Hartlepool Borough Council, Tees Esk and Wear Valley, Primary Care Networks across Stockton and Hartlepool and other key partners.

The proposal is demonstrated in the diagram below builds on existing partnership arrangements within the integrated Single Point of Access, the integrated Urgent Care Centres across Stockton and Hartlepool and health and social care teams at place.



Benefits of the investment

- Creating a work force for the future
- Patient centred care – at home 24/7
- Exploring further opportunities for partnership working across ageing well and urgent care work streams
- Further development of a system infrastructure that will support EHiCH and Anticipatory Care ambitions.

Additionally, work is underway to develop virtual wards (respiratory and frailty), as well as setting up interfaces between systems, e.g. the newly developed 'Optimised Patient Tracking & Intelligent Choices Application' (OPTICA) IT system. This will help avoid unnecessary hospital admissions and facilitate timely discharge with better quality an quicker access to information by both health and social care colleagues, which will assist with decision making.

Enhanced Health in Care Homes:
Now part of the Ageing Well programme and Primary Care Network DES, BCF funded services to support care homes have been in place for several years including the Care Home Training and Education Programme.

This is working well and good relationships with PCNs and Clinical Directors are in place, which have been strengthened during the pandemic response. Providers have been supported to access additional resources to manage infection control issues, as well as providing access to PPE, additional funding and support and guidance. This has supported providers to maintain their financial and operational stability.

As part of the DES care home round, community matrons undertake a proactive home round and have monthly multi-disciplinary teams with GP, pharmacy and nursing input as a minimum to support personalised care planning, alongside the care home nursing team.

Dedicated pharmacy support has been commissioned via the BCF to drive quality regarding medicine management, review of 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 including: • NHS Mail. • Proxy ordering of medication. • Personalised care and support planning. • Information sharing. In partnership with the wider North East councils, a regional technology group has been established to support technology based developments.	

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

BCF Governance arrangements

Each partner has their own internal governance arrangements in line with their own organisations requirements. These link to the broader governance arrangements of BCF. Together these arrangements ensure that a system wide perspective and approach is taken with appropriate oversight from the Health & Wellbeing Board.

The governance for our BCF Plan is illustrated in the embedded slide below:

Tees Valley BCF Governance Overview

We have regular meetings of the BCF Delivery Group which is formed of commissioning, finance and BCF leads from the Local Authority and ICB. This Group collectively plans, reviews new business cases, and monitors expenditure of the Better Care Fund.

The Pooled Budget Partnership Board receives recommendations from the BCF Delivery Group. The Board has senior membership from the Local Authority and the ICB and its role is to provide strategic direction on schemes and receive and approve business cases for proposals against the Better Care Fund.

The Stockton-on-Tees Health & Wellbeing Board is responsible for; signing off and ensuring delivery on the Stockton-on-Tees Better Care Fund Plan; ensuring that the BCF plan responds to local needs, is aligned with the Health & Wellbeing Strategy and supports system integration across health and social care; agreeing the use of funding under the Better Care Fund pooled budget arrangements; addressing any risks and issues arising that relate to the wider Stockton-on-Tees health and social care system; and progressing any joint commissioning implications and requirements arising from the Better Care Fund. The Board meets monthly. The membership of the Board comprises of:

- Stockton-on-Tees Borough Council (SBC) (Elected Members and Officers)
- North East and North Cumbria Integrated Care Board (ICB)
- Public Health
- Healthwatch
- NHS England
- Tees, Esk and Wear Valley NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- Hartlepool and Stockton Health - GP Federation
- Police and Crime Commissioner
- Voluntary and Community Sector representatives

SBC also hosts quarterly Providers Forum to engage and communicate with social care providers. Relevant representatives from TEWV NHS Trust, NTH NHS Trust, ICB are also invited to the Forum. SBC Housing Department also hosts quarterly meetings with the housing sectors to ensure partner organisations are engaged and involved.
Stockton-on-Tees BCF plan is jointly agreed by the SBC and ICB partners and are placed into a pooled fund which is governed by Section 75 of the NHS Act 2006. The plan and its delivery are adhering to the Act sections:

- 14Z1 (duty to promote integration)

• 14Q (duty as to effectiveness and efficiency etc) • 14R (duty as to improvement in quality of services) • 14T (duty as to reducing inequality)	

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

The Stockton BCF budget funds a range schemes that continue to prove their value and provide the foundations to meet current challenges and emerging threats to the health and social care system in Stockton.

The schemes cover a wide range of areas including housing, integration, technology, workforce, market development and sustaining the voluntary sector.

Our overarching approach has been one of collaboration and, where appropriate, integration with a broad range of partners. Key partners include the Local Authority, the ICB, Primary Care Networks and the Foundation Trusts (in terms of delivery). Statutory partners are increasingly working more closely with the voluntary sector through Community Led Support initiatives, as well as with family carers.

This approach has enabled partners to strengthen community-based services and provides a platform to better respond to the requirements of the urgent care agenda, and to utilise opportunities that will emerge from the Ageing Well programme.

Management of workforce pressure

Following the peak of COVID, the Community Integrated Assessment Team (CIAT) within the Community Integrated Intermediate Care (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 particularly during winter pressure. Two WTE of Band 4 Therapy Assistant and 1 WTE of Band 6 Physiotherapist/Occupational Therapist to be recruited. It will continue to embed the collaborative approach with other teams within the CIIC. Increasing the resource in CIAT will strengthen this collaborative offer provided to patients through shared decision-making, personalised care and a multidisciplinary team approach. It will support the BCF outcomes on crisis response, admission avoidance and discharge to access.

Integrated Single Point of Access (iSPA)

iSPA provides a multi professional triage and care planning service to improve pathway access and delivery for health, social care and VCSE services ensuring people get access to the right early help and specialist support.

This strengthens information sharing, improves risk assessment and enhances joint decision making to ensure people and their families receive the right services at the right time.

During the COVID pandemic, the previous and continued investment in iSPA gave health and social care the infrastructure to be able to respond more flexibly and quickly to a dramatically changing landscape. Despite the enormity of the challenge, people continued to receive appropriate support in a timely and effective way.

The learning from this excellent response to one of the greatest challenges we have faced since the second world war is that we need to continue to invest in the iSPA to ensure that we have sufficient coordination, resources and flexibility across health and social care to address future needs and emerging threats.

The iSPA model has been evaluated as successful using the following criteria:

- Effective pathways for people requiring health and/or social care support
- Improved rates of response to referrals with timely decision making and a reduction in delays associated with information gathering and duplicated effort.
- Reduction in the number of hospital admissions for people known to Out of Hospital services
- Reduction in the number of people requiring admission to care homes
- More holistic triage of people's needs.
- Increased referrals to non-statutory services for people with less complex needs.
- Reduction in the number of bed days in hospital, which frees up health resources to meet growing demand and focus on key areas, such as acute care.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting 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

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Following the introduction of new Hospital Discharge Operational Guidance, we have revised and re-energised discharge arrangements. We have enhanced previous arrangements and strengthened monitoring of all hospital discharges. We have intensified our focus on the notification process (which brought multi agency discussions much later in the process) and the previous formal reporting that focussed on DTOCs which challenged integration by way of the data reporting definitions. We welcome the removal of the DTOC process that was more focused on the concept of 'blame' for delays rather emphasising that this was a shared responsibility.

The shift to a 'Home First' approach means that discharge planning starts on admission with a daily clinically led review that uses the 'criteria to reside' ensuring that anyone remaining in an acute bed meets one of these 11 criteria and where they no longer meet the criteria they are discharged as soon as possible on the same day or the following day.

The Tees Valley has established flexible surge meetings based on pressures and need. Meetings have been closely linked with place-based discharge groups to ensure patients are discharged and placed on the next stage of their pathway of care, maintain flow throughout the hospital and promote rapid and supported discharge from hospital to the most appropriate place for recovery in a planned manner rather than experiencing an extended length of stay in an acute hospital bed.

All partners work together to focus on ensuring that the person is provided with the right care, in the right place at the right time. This promotes opportunities to ensure that people stay well and they are safe and independent at home for longer.

We have focused on collaboration including operational elements as well as strategic commissioning between health and social care.

Operationally, the weekly Hartlepool and Stockton Discharge Group has collectively worked across the ICB, Trust and LAs to ensure delivery of the new Hospital Discharge Guidance offering mutual support and solutions to community bed provision including 'Designated Settings', workforce issues, pathways/ processes and development of a 'Home First' approach and associated scheme.

The Home First scheme which commenced in November 2020 ensures people who need care receive it in the right setting. The new service supports patients to remain or return to their own home through provision of a 24/7 nurse led service, allowing for an individual to be both care managed and have their needs assessed within their own home environment by an appropriate integrated community workforce.

The Home First team is a multidisciplinary team that can deliver effective nursing and rehabilitation interventions during this initial period of up to 7 days to promote independence. The service works in collaboration with the integrated single point of access to support a health and social care approach to the delivery of care. Our ambition is to develop this to include a more robust link with the Telecare function.

Patients accessing the Home First pathway are generally:

- Suitable for Pathway 1 (able to return home with support from health and/or social care);
- Patients at the point of community crisis who require additional support to avoid escalation to Pathway 2 (rehabilitation or short-term care in a 24-hour bed-based setting); or
- Patients who have resolvable 1:1 needs.

This approach sits within a framework of joint commissioning and collaborative working where current and emerging challenges are discussed between all partners and appropriate solutions identified and implemented whenever possible.

In addition to the above we have completed a self-assessment against the High Impact Change Model and more recently against the new 100 day challenge initiatives, please see embedded document below.

NENC 100 Day Challenge RAG templa

In the coming months we aim to:

- Continue to progress the Amber areas identified in the 100 day challenge self-assessment
- Continue to embed and Implement OPTICA (Optimised Patient Tracking and Intelligence Choices Application) in particular the community element
- Assess if there are any gaps in the pathway 0 services supporting patients with low level needs to return home from hospital
- Review pathway 1 services, including Home First and community reablement, to develop an integrated discharge pathway
- Continue to map the current core intermediate care bed base capacity, operational models, workforce, contract and funding arrangements to ensure we are meeting national guidance and achieving best outcomes to inform commissioning intentions and the future bed-based model
- Agree discharge to assess pathways and financial model from April 2023 onwards

In terms of virtual wards and its role in enabling people to stay well, safe and independent at home for longer and provide the right care in the right place at the right time the 2022/22 planning guidance sets out a number of initiatives including a focus to improve the responsiveness of Urgent and Emergency Care (UEC) and to build community care capacity. The guidance asked systems to develop detailed plans to maximise the rollout of virtual wards to deliver care for patients who would otherwise have to be treated in hospital, by enabling earlier supported discharge and providing alternatives to admission. The focus of the virtual ward models including Acute Respiratory Infection and Frailty, as the evidence suggests that these specific groups account for up to 50% of patients who may be clinically suitable to benefit from a virtual ward. The goals of the virtual ward models are;

- To provide a virtual ward which is a safe and efficient alternative to NHS bedded care that is enabled by technology.
- To allow patients to receive the care they need at home, including care homes, safely and conveniently rather than in hospital.
- To provide systems with a significant opportunity to narrow the gap between demand and capacity for secondary care beds, by providing an alternative to admission and/or early discharge
- To promote equality and whilst addressing inequalities through the development of the virtual frailty ward and wider community services response
- To Invest in our workforce – with more people (for example, the additional roles in community services, new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

Across Stockton work is underway to develop virtual wards for respiratory and frailty with the aim of achieving the goals set out above.

Anticipatory Care

Many of our BCF schemes support the delivery of proactive care and support, particularly older people living with frailty to help them stay independent and healthy for as long as possible at home (or the place they call home).

Over the coming months our collective system including community health teams, Primary Care Networks, social care, mental health teams, community pharmacy, the housing and voluntary sector will be establishing or building on multi-disciplinary teams to strengthen relationships where required, delivering Anticipatory Care to an identified cohort of individuals. A key outcome will be that services will be transformed from being crisis driven to working in an integrated, personalised, and co-ordinated way for patients.

Priorities for this year and early 23/24 are:

- The development of clear ambitions for Anticipatory Care across the Tees Valley, working closely with providers and more specifically, PCNs to translate these ambitions into a comprehensive Anticipatory Care Plan

- To identify key segments of PCN's registered practice populations using risk stratification tools, who have complex needs and are at high risk of unwarranted health outcomes. Once this baseline/cohort has been developed, agree the number of individuals to be offered Anticipatory Care in 23/24

- To clinically validate individuals as appropriate for Anticipatory Care, prioritising those with greatest clinical need first

- To implement a holistic assessment process to understand the goals and ambitions of those identified as the Anticipatory Care cohort

Intermediate Care Beds (Rosedale Residential Centre)

Rosedale Residential Centre is a 44 bedded 24hr residential care home designed to prevent unnecessary hospital admission and to support hospital discharge through provision of rehabilitation of physical needs and/or assessment of long-term care needs. Residents come for a time limited period (up to 6 weeks). Rosedale provides holistic oversight of care needs with onsite community matron, social worker and therapy team 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 or 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 therapy 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.

Rapid Response Nurse

BCF has funded a 10. WTE Band 6 Rapid Response Nurse as part of the Home First Service at the front of house where the North Tees and Hartlepool NHS Foundation Trust have introduced nursing time and expertise to the wider offer. The role functions as part of the Home First offer alongside therapy staff and the Frailty Coordinators.

Block booked and Spot Purchased beds

Stockton-on-Tees BCF has commissioned beds in the independent care home market as part the hospital discharge policy (previously Discharge to Assess) for people with 24hr care needs. The beds are available for people up to 6 weeks whilst on going assessments take place. Beds are commissioned as a block contract or case by case spot arrangement.

Rapid Response Home Care

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

Home from Hospital Scheme

Home from Hospital Scheme aims to support patients who are being discharged from hospital to ensure the home environment is safe and they have sufficient food and medications as well as essential supply to reduce risk of readmission. The scheme supports patients for up to 14 days. The scheme also supports people to attend GP and hospital appointments, rebuild confidence and reduce isolation and loneliness.

Care Home Training and Education Programme

The programme is led by the Education and Organisational Development department within North Tees and Hartlepool NHS Foundation Trust who deliver the 'Well-Being of the Frail and Elderly Resident' training and support in collaboration with SBC and the TEWV NHS Foundation Trust. 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 (tertiary prevention) 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

Delivered by TEWV NHS Foundation 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. 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.

Care Home Protection Operational Group/ Social Care Protection Operational Group

In collaboration with SBC, NTH NHS Foundation Trust and TEWV NHS Foundation Trust, a Care Home Protection Operational Group/Social Care Protection Operational Group was set up during the first lockdown in 2020 which then expanded to encompass Care at Home Services later in the same year. The purpose of the group is to ensure that care homes and home care sectors are supported as much as possible to prevent and control Covid-19 by access to expert advice and information regarding infection prevention and control. The group acts as a conduit for agreement regarding the distribution of information to care homes and care at home services to ensure a consistent understanding and approach to communications. It has provided vital access of information and advice that is consistent with national guidance regarding Covid-19. Due to the successful collaboration and immense support to the sectors, it has been decided that the group to continue on a permanent basis and to provide ongoing general support to the sectors.

Staying Out

Staying Out is delivered by ARC which is a charity that uses arts and cultural activity to strengthen its local community. The scheme engages people aged 65+ who are residents of Stockton on Tees, and are leaving hospital, or recognised as being at high risk of readmission; as well as those identified as being socially isolated. Clients predominately identify as having chronic health conditions, including dementia, mental ill health, and Parkinson's Disease, and mobility, cognitive or sensory impairments. The scheme is designed to help participants stay active, remain independent, decrease hospital readmissions and poor mental/physical health, and lead fulfilling lives. It is a creative, 'social prescribing' alternative to day care, which uses weekly, artist-led creative arts activity to keep socially isolated older people active and signposts to other subsidised creative activities within ARC's main programme, or other activities and services in the area.

In summary, the key BCF plans to meet the national condition 4 are:

- A Home First scheme to prevent admission to hospital, support discharges home and provide overnight support if required
- A dedicated iSPA for D2A/hospital discharges, intermediate care and unplanned care which continues to be developed
- EHiCH and COVID has resulted in a drive to improve access to support and advice for care home residents and has provided:
    - Improvement in take up of NHS Mail

- Programme of work for medication management and proxy ordering
- Consistent approach to delivery of DES for older peoples care homes

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Support for unpaid carers:

Stockton Adult Carers Support Service is funded by BCF and delivered by SBC. We will maintain and develop support for Carers to sustain resilience by providing a Carer Support Service.

The 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, linking in with other community organisations to promote opportunities for peer support, training, and career opportunities. It works with carers to develop services that address issues include future and emergency planning support. The service is also looking at opportunities for carers to develop their skills via group support (i.e. Tea and Tech group).

The service promotes the take up of carers assessment with all carers including the opportunity to undertake self-assessment and supported self-assessment if appropriate. Providing carers with the space to examine the impact of the caring role on their own circumstances and wellbeing. Enabling the service to develop personalised, holistic support plans that address the unique challenges and difficulties for each carer and encourage the imaginative usage of carers personal budgets to promote the carers overall wellbeing. The service links in closely with adult social care to ensure robust support for carers and the cared for as required including linking with the hospital discharge team at North Tees Hospital to raise awareness of and address carers needs during the discharge process and beyond. This is an ongoing piece of work that remains high on the service agenda as something to be continually developed alongside the promotion of greater engagement from primary care partners including GP's surgeries.

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.

Our services include:

- Carers Assessment and Support Planning
- Carers Personal Budgets
- Carers Register
- Quarterly newsletter and other information
- Online and face to face peer support
- Carers Emergency Cards
- Time Out Support Service
- Carers Connect
- 1:1 and group support
- Support for carers in current employment
- Information, advice and signposting
- Awareness raising and education

Additionally, the Carers Support Service actively takes part in community events to support the general population to increase their awareness of services. This preventive and proactive approach helps to support the communities, particularly those who may not recognise or identify as a carer for a family member or friend.

The Carers Support Service also supports SBC employees with their unpaid carer responsibilities to promoting staff wellbeing.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Stockton is Unitary Authority therefore 100% of allocated DFG funding is available for residents across our borough.

Increased funding for DFG via the BCF made available in recent years to Local Authorities has ensured the provision of an efficient and effective DFG service. It has enabled the Local Authority to review existing arrangements to ensure that adaptations continue to play a significant supporting role in enabling the Boroughs residents remain independent in their homes for as long as possible, therefore avoiding un-necessary or early hospital or care home admissions. In addition to DFG's and in using the RRO we have in place the following to complement DFG's:

Equipment Loan scheme – SBC loan ramps, stair lifts and shower pods to support those residents with our borough with life limiting illness, supports safe hospital discharge, supports carers continue with their caring role and prevents admission to 24-hour care.

Discretionary financial assistance packages this scheme supports applicants who have to pay for work in excess of the maximum DFG grant award value or for those residents that do not have the financial means available to pay their financial contribution. This scheme prevents undue delays or applicants 'dropping out', which will inevitably place pressures on social and/or health services.

In addition to delivering our statutory DFG service, the SBC also operates a fast-track DFG service so we can respond quickly and effectively to the bespoke needs of individuals. As part of the new guidance issued on 28th March 2022 the Council is currently looking at further ways to support residents using RRO powers however this is in the early stages of at present and needs to go through the Council's process for ratification by Cabinet.

During 2021/22 Stockton Council delivered 416 adaptations 96 more than 2020/21. Of the 416 adaptations, 141 were DFG's, 195 Stairlift loans and 80 Ramp Loans.

The budget management and delivery of DFG lies with the SBCs Housing Regeneration and Investment Team, whilst the assessment of need (and identification of appropriate adaptations to address) lies with Occupational Therapy Team (part of the Adults and Health Directorate). Both teams work collaboratively to ensure a seamless service delivery. We continuingly seek to ensure that our service delivery remains fit for purpose and delivers value for money. In terms of value for money we continue to ensure effective procurement (often cross LA and/or with Registered Housing providers) with the aim of maximising the resources we have available and keeping waiting times to a minimum.

Any additional funding mid-year we may receive (which has been awarded previously) would be used to reduce the waiting list we have post COIVD-19.

Both teams have well established systems and procedures which facilitate collaborative working and expedient DFG application process. Over time the OT team has forged very

good working relationship and processes with health funded services e.g. McMillan Service, Community Stroke Team, Rosedale Rehab Team, and other teams under CIIC. This ensures that progressing DFG application happens without unnecessary delay. As part of the CIIC, the Occupational Therapy Team has developed an effective process of referring clients to the DFG Team directly. Furthermore, the Occupational Therapy Team has completed a recent proposal for delivery of OT services on behalf of CHC funded clients under s75 NHS Act 2006 and SLA is being drafted. This will ensure that CHC funded clients have timely access to OT assessments and DFG grant. This integrated approach of involving health, social care and housing is helping disabled clients access the DFG in a timely manner.

By using such discretionary powers, the council is seeking to prevent undue delays in provisions or applicants 'dropping out', which will inevitably place pressures on social and/or health services.

Furthermore, the Occupational Therapy Team has completed a recent proposal for delivery of OT services on behalf of CHC funded clients under s75 NHS Act 2006 and SLA is being drafted. This will ensure that CHC funded clients have timely access to OT assessments and therefore DFG grant.

There is an experienced Housing Occupational Therapist within the Occupational Therapy Team and all staff within the team undertake assessments of housing need for people and families where there is a significant change to health or medical condition which makes it difficult for them to function in the current home environment. In doing so OTs ensure that people are rehoused into suitable accommodation as quickly as possible and the scarce social housing stock is used appropriately. The OT Team arranges provision of minor aids and adaptations to people's houses as an interim measure whilst waiting to be rehoused.

To ensure the effective delivery of a holistic DFG service delivery model/effective pathway which supports independence (people remaining in their homes), quarterly strategic review meetings are held between lead managers (Housing, OT and Building Services). The purpose of these meetings is to review waiting list/service demands, explore new initiatives and were necessary and appropriate revise or update the service offered. For example, we are currently exploring whether the discretionary loan limit needs to be revised in response to significant building cost increases. Whilst this would support those awaiting large DFG's such as property extensions, the wider (potentially negative) impact this may have on the wider DFG waiting list also needs to be considered. The outcome of the reviews feed into both the DFG delivery service and the development BCF plans.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

SBC has published a Fairer Stockton Framework, which sets out a 10 year ambition to prevent, reduce and mitigate inequality. This focuses on the differing, unfair and avoidable differences between populations in our borough. Geographical communities and communities of identity experience inequality. The framework sets out approaches to understand and to respond so that inequality is not exacerbated by the design of our services. Indeed, service design and social value of services should mitigate inequality. To do so, we aim to work closely with our communities to understand and respond to their needs. A cabinet report with the Framework is embedded below:

Cabinet%20Report%20Fairer%20Stockton

In response to the Equality Act (2010), we recognise diversity in the design and accessibility of our services. We encourage 'access for all' in our mainstream services and actively pursue engagement with under-represented groups (e.g., BAME). We also provide targeted services to mitigate inequality e.g., Warm Home Healthy People and Better Wealth Better Health programmes.

We are working with the Ageing Well programme, to ensure Personalised Care approaches are fully embedded to support healthy ageing across the life course, as well as within the programme specific workstreams (Anticipatory Care, Urgent Community Response and Enhanced Health in Care Homes) and workforce competencies.

In addition, the ICS and the Tees Valley locality have robust plans around inequalities as can be seen in the embedded extract from the planning submission and a Tees Valley overview update which was compiled earlier this year (please see below).

These includes reference to our approach to Core20PLUS5, population health management and outlines the indicators available.

NENC ICS Planning Extract - Health Inequa

Health inequalities Tees Valley Overview.

We will ensure that our BCF schemes including the examples below continue to complement the local plans outlined above.

Warm Home Healthy People Programme

The Stockton-on-Tees BCF has invested £100,000 for the Warmer Homes Healthy People (WHHP) Programme to create positive outcomes for people in relation to the integration of health, social care and housing. It 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. The programme runs from October to March each year.

The programme focuses on the most vulnerable households, particularly those with the highest needs and whose health and wellbeing is more likely to be negatively impacted without intervention. The measures include:

- Income maximisation by identifying unclaimed benefits
- Register for the Warm Home Discount and the Priority Services
- Improve energy efficiency
- Providing emergency heaters by the Cleveland Fire Brigade to household with no heating
- Offer specific energy advice and support for those with dementia and their carers
- Income maximisation advice and support into the summer of 2021 in recognition of reduced income levels in already deprived areas during the COVID-19 Pandemic.

Better Wealth Better Health Scheme

The Scheme is delivered by AgeUK Teesside which is a charitable organisation, to provide interventions for those aged over 65 who live in the borough of Stockton-on-Tees. The aims of the project are 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 including befriending and welfare advice. The scheme provided a consistent and valuable service to vulnerable clients during the Covid 19 pandemic especially during periods of lockdown when befriending moved to telephone or electronic means but increased in frequency. Group activities continued online, and isolated members of the community were reached with activity packs delivered to their homes. After lifting of all COVID restrictions, face-to-face activities have been resumed with individual risk assessment and adherence to government guidance.

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Stockton-on-Tees
Completed by:	Yvonne Cheung
E-mail:	yvonne.cheung@stockton.gov.uk
Contact number:	01642 524577
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	
If using a delegated authority, please state who is signing off the BCF plan:	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Councillor
Name:	Jim Beall

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Jim	Beall	jim.beall@stockton.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		David	Gallagher	dgallagher@nhs.net
	Additional ICB(s) contacts if relevant				@
	Local Authority Chief Executive		Julie	Danks	julie.danks@stockton.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Ann	Workman	ann.workman@stockton.gov.uk
	Better Care Fund Lead Official		Emma	Champley	emma.champley@stockton.gov.uk
	LA Section 151 Officer		Garry	Cummings	garry.cummings@stockton.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Stockton-on-Tees

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,804,655	£1,804,655	£0
Minimum NHS Contribution	£16,637,994	£16,637,994	£0
iBCF	£7,171,908	£7,171,908	£0
Additional LA Contribution	£200,000	£200,000	£0
Additional ICB Contribution	£0	£0	£0
Total	**£25,814,557**	**£25,814,557**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£4,844,388
Planned spend	£5,299,746

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£8,673,500
Planned spend	£11,246,516

Scheme Types

Assistive Technologies and Equipment	£1,981,000	(7.7%)
Care Act Implementation Related Duties	£791,000	(3.1%)
Carers Services	£474,770	(1.8%)
Community Based Schemes	£1,050,294	(4.1%)
DFG Related Schemes	£1,804,655	(7.0%)
Enablers for Integration	£191,311	(0.7%)
High Impact Change Model for Managing Transfer of (	£2,113,272	(8.2%)
Home Care or Domiciliary Care	£1,112,105	(4.3%)
Housing Related Schemes	£100,000	(0.4%)
Integrated Care Planning and Navigation	£3,510,142	(13.6%)
Bed based intermediate Care Services	£2,005,021	(7.8%)
Reablement in a persons own home	£1,532,759	(5.9%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£1,766,908	(6.8%)
Prevention / Early Intervention	£1,503,320	(5.8%)
Residential Placements	£5,878,000	(22.8%)
Other	£0	(0.0%)
Total	**£25,814,557**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)			

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.9%	93.1%	93.5%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	620	654

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.4%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Stockton-on-Tees

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Stockton-on-Tees	£1,804,655
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,804,655**

iBCF Contribution	Contribution
Stockton-on-Tees	£7,171,908
Total iBCF Contribution	**£7,171,908**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Stockton-on-Tees	£200,000	From public health grant
Total Additional Local Authority Contribution	**£200,000**	

NHS Minimum Contribution	Contribution
NHS North East and North Cumbria ICB	£16,637,994
Total NHS Minimum Contribution	**£16,637,994**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding

Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£16,637,994**	

	2021-22
Total BCF Pooled Budget	**£25,814,557**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Stockton-on-Tees

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,804,655	£1,804,655	£0
Minimum NHS Contribution	£16,637,994	£16,637,994	£0
iBCF	£7,171,908	£7,171,908	£0
Additional LA Contribution	£200,000	£200,000	£0
Additional NHS Contribution	£0	£0	£0
Total	**£25,814,557**	**£25,814,557**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,844,388	£5,299,746	£0
Adult Social Care services spend from the minimum ICB allocations	£8,673,500	£11,246,516	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Multi Disciplinary Community Teams	Reablement funding	Reablement in a persons own home	Reablement service accepting community and		Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution	£766,998	Existing
1	Multi Disciplinary Community Teams	Reablement funding	Reablement in a persons own home	Reablement service accepting community and		Community Health		Joint	50.0%	50.0%	NHS Community Provider	Minimum NHS Contribution	£765,761	Existing
1	Multi Disciplinary Community Teams	MDS Team	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution	£486,590	Existing
1	Multi Disciplinary Community Teams	Core services	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,442,400	Existing
1	Multi Disciplinary Community Teams	Core services	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£797,021	Existing
1	Multi Disciplinary Community Teams	VCSE Schemes	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£88,810	Existing
1	Multi Disciplinary Community Teams	Welfare Advice	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum NHS Contribution	£49,440	Existing

1	Multi Disciplinary Community Teams	Single Point of Access	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£155,041	Existing
1	Multi Disciplinary Community Teams	Single Point of Access	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£115,680	Existing
1	Multi Disciplinary Community Teams	Homecare Service - Discharge to Assess	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	Minimum NHS Contribution	£180,105	Existing
1	Multi Disciplinary Community Teams	Care home training programme	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£150,531	Existing
1	Multi Disciplinary Community Teams	Medication support in care homes	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£59,488	New
1	Multi Disciplinary Community Teams	Community matron in Rosedale	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£95,307	Existing
2	Improving Pathways and Care for Dementia	Core services	Bed based intermediate Care Services	Rapid/Crisis Response		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£1,358,271	Existing
2	Improving Pathways and Care for Dementia	Core services	Community Based Schemes	Other	Day care - Halcyon Centre	Mental Health		LA			Local Authority	Minimum NHS Contribution	£325,700	Existing
2	Improving Pathways and Care for Dementia	ICLS Service	Bed based intermediate Care Services	Rapid/Crisis Response		Mental Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£184,454	Existing
2	Improving Pathways and Care for Dementia	Livewell Hub & Dementia Advisors	Community Based Schemes	Multidisciplinary teams that are supporting		Mental Health		LA			Local Authority	Minimum NHS Contribution	£145,594	Existing
3	Digital Care	Falls prevention in care homes	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£60,000	Existing
4	ICT Systems and Data Sharing	MIG	Enablers for Integration	System IT Interoperability		Primary Care		CCG			CCG	Minimum NHS Contribution	£32,953	Existing
5	Transformation Managers	Additional workforce	Enablers for Integration	Programme management		Social Care		LA			Local Authority	Minimum NHS Contribution	£58,357	Existing
6	Care Act Implementation	Advocay & Carers Support	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£691,000	Existing
7	Carers Services	Carers Support Service	Carers Services	Other	Carers Support Services	Social Care		LA			Local Authority	Minimum NHS Contribution	£474,770	Existing
8	Protection of Social Care	OneCall (Telecare)	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£305,000	Existing
8	Protection of Social Care	Homecare Service - Discharge to Assess	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£160,000	Existing
8	Protection of Social Care	Community based equipment	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,516,000	Existing

8	Protection of Social Care	Homecare Services	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum NHS Contribution	£772,000	Existing
8	Protection of Social Care	Residential Care	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum NHS Contribution	£786,000	Existing
8	Protection of Social Care	LA Day Services for Dementia	Community Based Schemes	Other	Day care - Halcyon Centre	Social Care		LA			Local Authority	Minimum NHS Contribution	£165,000	Existing
8	Protection of Social Care	Extra Care	Residential Placements	Extra care		Social Care		LA			Local Authority	Minimum NHS Contribution	£192,000	Existing
8	Protection of Social Care	Early Intervention & Assessment Teams	Prevention / Early Intervention	Other	Early Intervention & Assessment	Social Care		LA			Local Authority	Minimum NHS Contribution	£900,000	Existing
8	Protection of Social Care	LA Direct Payments	Community Based Schemes	Other	Direct Payments	Social Care		LA			Local Authority	Minimum NHS Contribution	£300,000	Existing
8	Protection of Social Care	Protection of social care	Prevention / Early Intervention	Other	Protection of social care	Social Care		LA			Local Authority	Minimum NHS Contribution	£465,070	Existing
9	Protection of Community Health	Protection of Community Health	High Impact Change Model for Managing Transfer	Early Discharge Planning		Community Health		CCG			CCG	Minimum NHS Contribution	£1,321,357	Existing
10	DFG	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£721,862	Existing
10	DFG	DFG Related Schemes	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£1,082,793	Existing
11	Warm Homes Health People	Home improvements	Housing Related Schemes			Social Care		LA			Local Authority	Additional LA Contribution	£100,000	Existing
11	Falls prevention service	Falls prevention	Bed based intermediate Care Services	Rapid/Crisis Response		Social Care		LA			Local Authority	Additional LA Contribution	£100,000	Existing
12	Improved Better Care Fund	Direct Payments	Personalised Care at Home	Other	Direct Payments	Social Care		LA			Local Authority	iBCF	£600,000	Existing
12	Improved Better Care Fund	OneCall (Telecare)	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	iBCF	£100,000	Existing
12	Improved Better Care Fund	DOLS / LPS Implementation	Care Act Implementation Related Duties	Other	DOLS / LPS Implementation	Social Care		LA			Local Authority	iBCF	£100,000	Existing
12	Improved Better Care Fund	Rapid Response Capacity	Bed based intermediate Care Services	Rapid/Crisis Response		Community Health		CCG			NHS Community Provider	iBCF	£91,000	Existing
12	Improved Better Care Fund	Transformation Managers	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	iBCF	£100,000	Existing
12	Improved Better Care Fund	LD Services Review	Community Based Schemes	Other	LD Services	Social Care		LA			Local Authority	iBCF	£114,000	Existing

12	Improved Better Care Fund	Protection of Social Care - Residential Care	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£1,800,000	Existing
12	Improved Better Care Fund	Protection of Social Care - Residential Care	Residential Placements	Nursing home		Social Care		LA			Local Authority	iBCF	£1,700,000	Existing
12	Improved Better Care Fund	Protection of Social Care - Care at Home	Residential Placements	Supported living		Social Care		LA			Local Authority	iBCF	£1,400,000	Existing
12	Improved Better Care Fund	Protection of Social Care - Care at Home	Personalised Care at Home	Physical health/wellbeing		Social Care		LA			Local Authority	iBCF	£1,166,908	Existing
13	Discharge to Assess	Continuation of Discharge to Assess in care homes	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£271,297	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Stockton-on-Tees

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	285.3	246.5	282.9	194.2	20/21 & 21/22 data impacted by Covid - 22-23 trajectory set as mid-point between 19/20 and 21/22 activity levels (ISR rates - Q1 294, Q2 272, Q3 312, Q4 280)	We will aim to meet the ambition through our BCF funded admission avoidance and prevention schemes as well as wider initiatives such as UCR, Ageing Well and virtual ward.
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	294	272	312	280		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.3%	93.1%	93.7%	93.4%	Plan aims to increase performance from 21/22 which was above the national average. Quarter 1 included as actual and Quarters 2-4 forecasted on planning submissions.	We have several schemes and initiatives in place to support this including our Home First Service. Our agreement to continue to fund 4 weeks discharge to assess could potentially mean fewer people are discharged straight from hospital to 'home' but maximises their potential to do so.
	Numerator	4,398	4,455	4,516	4,382		
	Denominator	4,714	4,784	4,822	4,692		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	93.9%	93.1%	93.5%	93.4%		
	Numerator	4,748	3,793	3,468	3,825		
	Denominator	5,056	4,073	3,709	4,096		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	619.8	790.2	659.9	653.8	20-21 and 21-22 data impacted by COVID - 22-23 trajectory set as mid-point between 19/20 and 21/22 activity levels	Continued plan is to work closely with the Trust, the Home First service, our Direct Care Team and the independent domiciliary care providers to support people to return to their own homes and other alternatives to residential care,
	Numerator	229	297	248	251		
	Denominator	36,948	37,583	37,583	38,391		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.3%	86.0%	85.4%	85.4%	Plan to maintain already high performance from 21/22 - this is above the national average	Proactive analysis of those coming out of hospital is used to monitor performance and provide continual feedback, as well as putting in place a range of different options and support to help people stay at home following discharge from hospital.
	Numerator	44	129	41	41		
	Denominator	51	150	48	48		

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Stockton-on-Tees

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes			
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			