Stockton-on-Tees BOROUGH COUNCIL
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# Health & Wellbeing Board

Agenda

**Date:** Wednesday 27 November 2024 at 2.00 pm

**Venue:** Jim Cooke Conference Suite, Stockton Central Libary, Church Road, Stockton on Tees, TS18 1TU

**Cllr Robert Cook (Chair)**
**Cllr Lisa Evans (Vice-Chair)**

Cllr Pauline Beall
Cllr Dan Fagan
Cllr David Reynard
Cllr Marcus Vickers
Majella McCarthy
Sarah Bowman-Abouna
Dominic Gardner
Peter Smith
Michael Houghton
Lucy Owens
Cllr Diane Clarke OBE
Cllr Steve Nelson
Cllr Stephen Richardson
Cllr Sylvia Walmsley
Carolyn Nice
Fiona Adamson
Jonathan Slade
Karen Hawkins
Matt Storey

## AGENDA

**1 Evacuation Procedure**

**2 Apologies for absence**

**3 Declarations of interest**

**4 Minutes**

To approve the minutes of the last meeting held on 30 October 2024. (Pages 7 - 8)

**5 Stockton Better Care Fund Update** (Pages 9 - 28)

**6 Members' Updates**

**7 Forward Plan** (Pages 29 - 30)

**Members of the Public - Rights to Attend Meeting**

With the exception of any item identified above as containing exempt or confidential information under the Local Government Act 1972 Section 100A(4), members of the public are entitled to attend this meeting and/or have access to the agenda papers.

Persons wishing to obtain any further information on this meeting, including the opportunities available for any member of the public to speak at the meeting; or for details of access to the meeting for disabled people, please

Contact: Michael Henderson on email Michael.henderson@stockton.gov.uk

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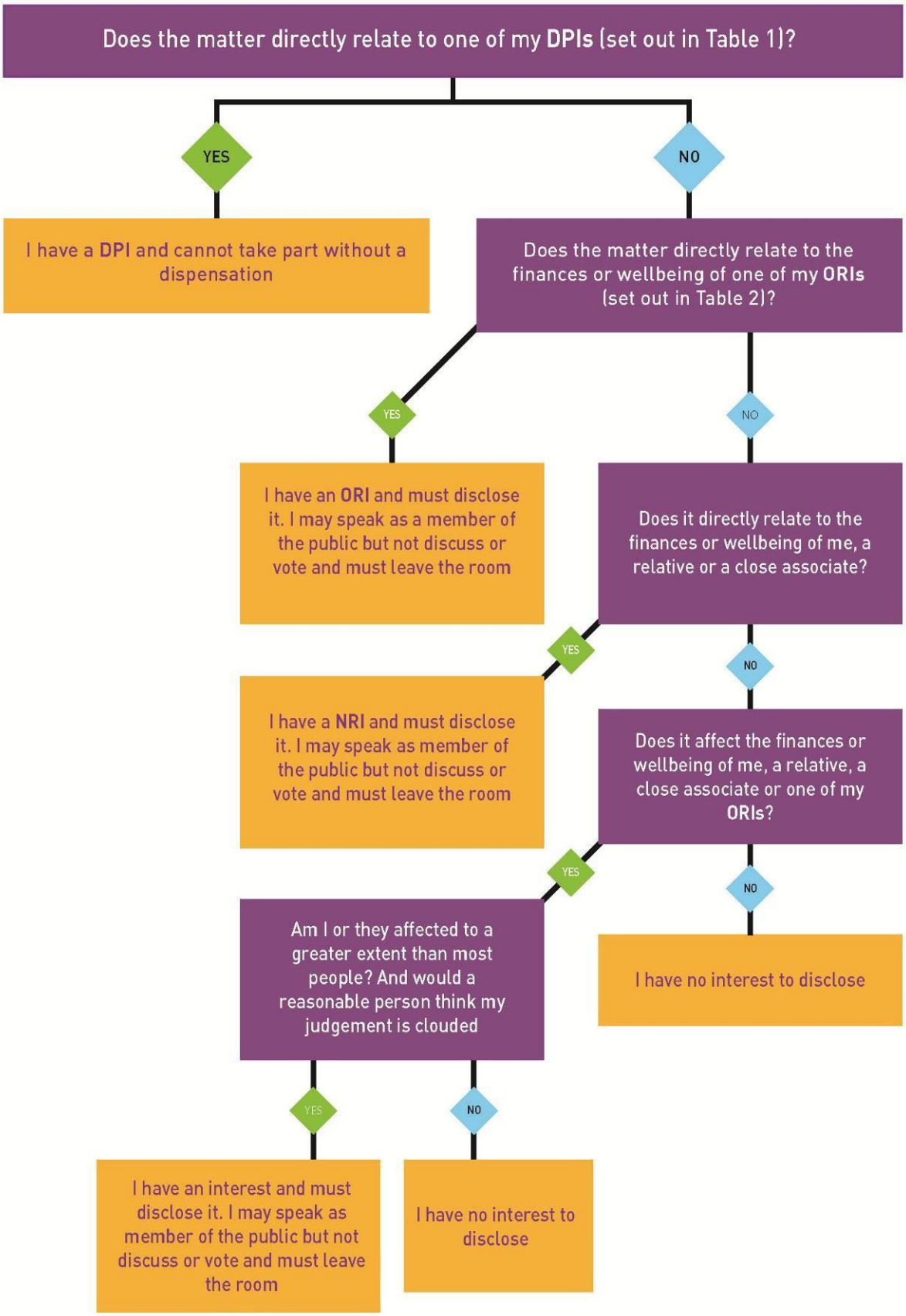
**KEY - Declarable interests are:-**

- Disclosable Pecuniary Interests (DPI's)
- Other Registerable Interests (ORI's)
- Non Registerable Interests (NRI's)

## Members – Declaration of Interest Guidance



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# Table 1 - Disclosable Pecuniary Interests

| Subject | Description |
|---|---|
| **Employment, office, trade, profession or vocation** | Any employment, office, trade, profession or vocation carried on for profit or gain |
| **Sponsorship** | Any payment or provision of any other financial benefit (other than from the council) made to the councillor during the previous 12-month period for expenses incurred by him/her in carrying out his/her duties as a councillor, or towards his/her election expenses.<br>This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992. |
| **Contracts** | Any contract made between the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners (or a firm in which such person is a partner, or an incorporated body of which such person is a director* or<br><br>a body that such person has a beneficial interest in the securities of*) and the council —<br>(a) under which goods or services are to be provided or works are to be executed; and<br>(b) which has not been fully discharged. |
| **Land and property** | Any beneficial interest in land which is within the area of the council.<br>'Land' excludes an easement, servitude, interest or right in or over land which does not give the councillor or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners (alone or jointly with another) a right to occupy or to receive income. |
| **Licences** | Any licence (alone or jointly with others) to occupy land in the area of the council for a month or longer. |
| **Corporate tenancies** | Any tenancy where (to the councillor's knowledge)—<br>(a) the landlord is the council; and<br>(b) the tenant is a body that the councillor, or his/her spouse or civil partner or the person with whom the councillor is living as if they were spouses/ civil partners is a partner of or a director* of or has a beneficial interest in the securities* of. |
| **Securities** | Any beneficial interest in securities* of a body where—<br>(a) that body (to the councillor's knowledge) has a place of business or land in the area of the council; and<br>(b) either—<br>(i) the total nominal value of the securities* exceeds £25,000 or one hundredth of the total issued share capital of that body; or<br>(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the councillor, or his/ her spouse or civil partner or the person with whom the councillor is living as if they were spouses/civil partners have a beneficial interest exceeds one hundredth of the total issued share capital of that class. |

* 'director' includes a member of the committee of management of an industrial and provident society.

* 'securities' means shares, debentures, debenture stock, loan stock, bonds, units of a collective investment scheme within the meaning of the Financial Services and Markets Act 2000 and other securities of any description, other than money deposited with a building society.

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## Table 2 – Other Registerable Interest

You must register as an Other Registrable Interest:

a) any unpaid directorships

b) any body of which you are a member or are in a position of general control or management and to which you are nominated or appointed by your authority

c) any body

(i) exercising functions of a public nature

(ii) directed to charitable purposes or

(iii) one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union) of which you are a member or in a position of general control or management

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# Health & Wellbeing Board

A meeting of Health & Wellbeing Board was held on Wednesday 30 October 2024.

**Present:** Cllr Bob Cook (Chair), Cllr Lisa Evans, Cllr Pauline Beall, Sarah Bowman Abouna, Dr Deepak Dwarakanath, Karen Hawkins, Cllr Steve Nelson, Dominic Gardner, Lucy Owens, Peter Smith, Jane Smith (sub for Majella McCarthy), Cllr Marcus Vickers, Cllr John Coulson (Sub for Cllr Diane Clark OBE), Cllr Sylvia Walmsley

**Officers:** Michael Henderson

**Also in attendance:**

**Apologies:** Fiona Adamson, Diane Clark OBE, Carolyn Nice, Cllr Dan Fagan, Cllr David Reynard, Cllr Stephen Richardson, Jonathan Slade, Matt Storey, Majella McCarthy

## 1 Declarations of Interest

There were no declarations of interest.

## 2 Minutes of the Meeting held on 25 September 2024

RESOLVED that the minutes be confirmed as a correct record and signed by the Chair.

## 3 Care and Health Winter Planning update

Members considered a report that provided an update on care and health winter planning work, across the Council, working with partners.

Discussion and key points, included:-

- Any admission avoidance work would be important, as bed capacity at North Tees Hospital would likely be under pressure.
- The Local Area Delivery Board was promoting a campaign that included a particular focus on winter vaccinations.
- Outreach vaccination sessions would be part of the programme.

RESOLVED that the plan be noted and endorsed

## Tees Valley Area ICP Meeting Minutes

The minutes of the Tees Valley Area ICP Meeting held on 9 August 2024 were noted.

## 6 Members' Updates

There were no updates

## 7 Health and Wellbeing Board – Forward Plan

The Right Person Right Care report would initially be scheduled for November.

Healthwatch's review of dentistry was largely completed, though some

additional engagement was currently underway. Draft recommendations had been compiled and these were being considered by commissioners and other interested parties. The final report would be presented to Board and would be highlighted in the Forward Plan ‘to be scheduled’.

Consideration would be given to including an item on ‘Dental attendance for Children in our care’ on the Forward Plan.

A winter plan presentation that was being provided to Tees Valley Joint Scrutiny, by the Local Area Delivery Board, would be made available to Board members.

RESOLVED that the forward plan be noted.

**AGENDA ITEM**

**REPORT TO HEALTH AND WELLBEING BOARD**

**27th November 2024**

**REPORT OF: Better Care Fund (BCF)**

## STOCKTON BETTER CARE FUND UPDATE

### Stockton BCF Quarter 2 report

### SUMMARY

The purpose of this paper is to provide the Health and Wellbeing Board with an update on the submission of the Quarter 2 report to the NHS England on 31st October 2024.

### RECOMMENDATIONS

The Health and Wellbeing Board are asked to:

1. Note the submission of the Stockton-on-Tees BCF Quarter 2 report to NHS England as part of the reporting requirements set out in the BCF Planning Requirements 23-25.

### Background

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS). The key purposes of BCF reporting are:

1) To confirm the status of continued compliance against the requirements of the fund (BCF).
2) In Quarter 2, to demonstrate performance against the BCF metrics, capacity and demand on intermediate care and expenditure on all BCF schemes.

### Summary of the Q2 report

The aim of the report was to provide information on assessment of progress, activities and expenditure in Q2. The sections of the report include:

- Tab 3: National Conditions: to confirmed that the four BCF National Conditions were met. They include:
    - Jointly agreed plan.

  - Implementing BCF objective 1: Enabling people to stay well, safe and independent at home for longer.
  - Implementing BCF objective 2: Providing the right care in the right place at the right time.
  - Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.
- Tab 4: Metrics – planned metrics were agreed as part of the BCF Plan 24/25 which was submitted in June 2024. At the time of the Q2 submission, data was still in the process of validation, therefore it was not available. However, the Q2 report did not require performance. The aim was to seek a best estimate of confidence on progress against the achievement of metric ambitions. Q2 data should be available in December and will be used to assess progress in Q3 reporting. Table below shows the assessment of progress.

| Metrics | Planned performance 24/25 (pre-populated) | | | | Q1 24/25 (pre-populated) | Assessment of progress | Challenges and support needs | Achievements and actions to support improvements |
|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | | | | |
| Avoidable admission | 295 | 200.5 | 234.5 | 212.4 | 272.3 | On track to meet target | Q1 shows slightly lower admissions than anticipated which is positive. Q2 data is unavailable at this point however this will be reviewed when it becomes available. No support requirements at this stage | BCF funded admission avoidance and prevention schemes as well as wider initiatives such as UCR, Ageing Well and virtual ward. |
| Discharge to normal place of residence | 93.9% | 93.9% | 93.9% | 93.9% | 93.47% | On track to meet target | Q1 shows slightly lower percentage of discharges to normal place of residence. Q2 data is unavailable at this point however we will review when this becomes available. No support requirements at this stage | We have several schemes and initiatives in place to support this including our Home First Service. Our ongoing 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. |
| Falls | 1,469.9 | | | | 379.2 | On track to meet target | Q1 shows slightly higher (3%) than anticipated. Q2 data is unavailable at this point | A project has been initiated across Tees to scope, map, review and redesign the |

| | | | | | |
|---|---|---|---|---|---|
| | | | | however we will review when this becomes available. | existing pathways across the system responding to Level 1 & 2 falls in the community. |
| Residential admissions | 458 | Not applicable | Not on track to meet target | Q2 continues to show a projected increase in the number of permanent residential placements being made for the 24/25 financial year. This is being addressed with changes to the process for agreeing care and support. | Home First processes are ensuring short term / assessment beds are effective and permanent residential placements are appropriate (all other options, including technology, have been considered). |

- 5.1 Capacity and Demand Assumption: there has been no change in assessing the capacity since the submission of the BCF plan 24/25 in June. Narratives were included to explain a technical error which showed a pre-populated demand in short term domiciliary care as 0, however, our plan was 59 to 61 per month.
- 5.2 Capacity and demand actual activity - provided actual demand and activities data on intermediate care services for hospital discharge and community. Prepopulated demand was calculated based on activities from previous year. Actual demand on Q1 and Q2 for Reablement and rehabilitation in bed setting was slightly higher than predicted, however, demand for short term residential or nursing for someone who is likely to need long term care home placement was lower than predicted.
- 6b – Expenditure: Provided cumulative spend for all schemes and outputs for schemes specified by the National BCF team.

**Copy of the full report**

Q2%20Reporting%20Template%20FINAL

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Rob Papworth, Strategic Development Manager, Stockton-on-Tees Borough Council, rob.papworth@stockton.gov.uk

Kathryn Warnock, Head of Commissioning and Strategy, NHS Tees Valley Clinical Commissioning Group
kathryn.warnock@nhs.net

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# Stockton-on-Tees Better Care Fund

Suggested presenters

Yvonne Cheung SBC

Kathryn Warnock ICB

Angela Grady/Lynne Calder NTH NHS Trust

Jordan Cummings TEWV NHS Trust

NHS Tees, Esk and Wear Valleys NHS Foundation Trust

NHS North East and North Cumbria

North Tees and Hartlepool NHS NHS Foundation Trust

# Better Care Fund

BCF is a programme that supports local systems to successfully deliver the integration of NHS  and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

# Vision of BCF

Enable everyone to live at home longer, be healthier and get the right support where required, whether this be provided by NHS, social care and/or VCSE

- Integrated NHS and Social Care
- Primary prevention
- Early diagnosis and intervention
- Supported self-management
- Closing health and wellbeing gap
- Reduce inequalities
- Transformation to close care and quality gap

# Metrics

Avoidable admission

Falls related hospital admission

Discharge to usual place of residence

Residential admission

Reablement

# Case study 1 – Hospital discharge

- A 76 years old gentleman was transferred to Rosedale for rehabilitation following admission to North Tees Hospital due to a fall at home and long lie.
- He had urine infection which caused delirium which was resolved while in hospital. He was previously independent and lives at home alone.
- He was assessed by the therapy team in Rosedale, He required assistance of 1 with a wheeled zimmer frame and for all transfers.
- After 5 days he was independent with transfers and walked approx. 30 metres with a 4 wheeled walker. He continued with step practice. He completed kitchen practice and made his own cup of tea.
- He required support with washing and dressing lower body initially. Support workers continued washing and dressing practice and he became independent after a few days.
- After 12 days, he was discharged home with Reablement support.

# Interventions

## Rosedale

Community Matron visited the gentleman on the ward for initial review.

District Nurse referral on admission to Rosedale to change dressings due to pressure sore.

Rosedale Therapy involved to provide rehabilitation to improve mobility:

- Mobility practice with parallel bars and throwing bean bags onto coloured mats, standing balance exercises, chair and bed transfers.
- Step practice with 5 inch and 7 inch wooden step (gentleman lives in a bungalow).
- Kitchen practice
- Home visit identified equipment required (high backed chair and bed lever).

## Reablement

Reablement team visited once a day, each morning.

- To observe and monitor progression at home with daily tasks.
- Due to two falls after returning home, support remained in place to continue to monitor and provide necessary support. A fall assessment was carried, risks of fall were modified through assistive equipment and education on home safety.
- He was encouraged to wear pendant alarm as a means of summoning help to prevent long lie in an event of a fall.

# Outcomes

- Supported timely hospital discharge.
- Continued with rehabilitation in a 24 hours care setting before being discharged home with support to maximise safety and independence.
- Continued progression once at home, increased confidence in independent completion of tasks.
- Increased awareness and compliance with home safety equipment.
- Risks of fall were modified.
- Time spent with the support in place allowed this person to remain at home independently without the need of further service intervention.
- Service ended within three weeks
- Positive feedback received from the individual **who stated that the girls are a credit to the service, feeling valued and stating all support was delivered with dignity and respect.**

# Case study 2 – Support in the Community

- An urgent referral for received via NEAS Bleep into Community Integrated Assessment Team (CIAT).
- A gentleman fell when trying to walk to the toilet at home with no obvious injuries. He lives with his wife and was independent prior to the fall.
- CIAT arrived within 30 minutes. He was laid on the bathroom floor. A full body screening and clinical observations were taken. He presented with acute confusion. Staff used a slide sheet to move him to the corridor so he could be safely raised from the floor using a Raiser.
- Assessment identified that he required assistance of one with a wheeled zimmer frame for mobility and his wife was unable to provide support for personal care.
- Referred to Virtual Frailty Ward for further clinical assessments, treatment and observation
- Referred to Reablement Service for further support

# Interventions

**Therapy assessment – CIAT**

- Transfers and mobility assessment
- Provision of a wheeled zimmer frame, commode and toileting aids
- Ongoing therapy to return to previous level

**Medical Assessment** – Clinical Community Practitioners, Virtual Frailty Ward

- Medical assessment queried Urinary infection
- Prescribed antibiotics
- Closely monitored by the VFW
- Clinical observation by Home First Team for 48 hours to prevent deterioration

**Social care –** Reablement Service

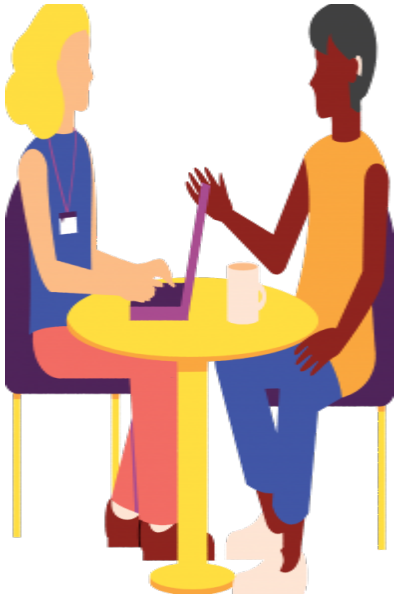
- Implemented short term care package twice daily for personal care

# Outcomes

- Prevented avoidable hospital admission.
- He was remained at home with wife and additional support while recovering from the urinary infection.
- Reablement support reduced from two calls a day to once a day after one week.
- Discharged from CIAT after 2 weeks.
- He regained his independence and was discharged from Reablement in week 3.

# Case study 3 – Mental Health Support

- An 89 years old man with multiple co-morbidities was referred to the Virtual Frailty Ward by his GP.
- He had delirium attributed to a urinary infection.
- His increased confusion with delusion brought attention to the Integrated Community Liaison Service during the Multidisciplinary meeting.
- He lives alone with family support.  He has bypassing catheter, Urinary Infection, abnormal blood results.



# Interventions

**Medication review - ISPA Pharmacist**

- De-prescribing medications no longer appropriate
- Prescribing antibiotics
- PRN for distress
- Insulin for newly identified diabetes

**Physical Health -** Clinical Care Practitioners, Home First Team, CIAT

- Bloods obtained, reviewed and actioned
- NEWS daily
- Assessment of mobility – equipment provided

**Social care -** ISPA Social Work Team

- Implemented short term care package to support family
- Carer support advice given

**Mental health -** ISPA Mental Health Practitioner

- Face to face assessment inclusive of the PINCHME
- 4AT assessment tool for delirium
- Onward referral to appropriate community mental health team

# Outcomes

- Prevented avoidable hospital admission.
- The person recovered and remained in his own home to promote independence.
- Care package to reduce carer strain.
- Reviewed of mental health and onward referral to community mental health team for support.
- Education and advice for family on delirium, and pre-existing mental health concerns and how these should be managed.
- An emergency healthcare plan was discussed and co-produced with the person and family members to manage the physical and mental health conditions.
- The person was discharged from the Virtual Frailty Ward.
- Details of the support and intervention was sent to the person's GP.


Any Questions?

# Agenda Item 7

## HEALTH AND WELLBEING BOARD - FORWARD PLAN

| | |
|---|---|
| 18 December 2024 | • Integrated Mental Health Strategy Group **(Sarah Bowman Abouna)**<br>• SEND Strategic Action Plan<br>• Physical Activity Steering Group Update **(Sarah Bowman Abouna)**<br>• Alcohol Strategic Group Update **(Sarah Bowman Abouna/Mandy McKinnon)**<br>• Tobacco Alliance Update**(Sarah Bowman Abouna/Mandy McKinnon)**<br>• Right Person, Right Care **(TEWV/Police/SBC)** |
| 29 January 2025 | • Joint Strategic Needs Assessment **(Sarah Bowman Abouna/Sid Wong)**<br>• Health Protection Collaborative Update **(Sarah Bowman, Rob Miller)**<br>• Members' Updates<br>• Forward Plan |
| 26 February 2025 | • Members' Updates<br>• Forward Plan |
| 26 March 2025 | • Domestic Abuse Steering Group Update **(Sarah Bowman Abouna/Mandy McKinnon)**<br>• Members Updates<br>• Forward Plan |
| 30 April 2025 | • Health Protection Collaborative Update **(Sarah Bowman, Tanja Braun, Rob Miller)**<br>• Members' Updates |

| | |
|---|---|
| | • Forward Plan |

**To be scheduled:**

- Multiple Complex Needs – Peer Advocacy Pilot **(Sarah Bowman Abouna/Mandy Mackinnon)**
- Pharmacy Provision/ Update on Community Pharmacies **(ICB)**
- Primary Care Update (GPs, dentists and optometry) **(ICB – Emma Joyeux)**
- Fairer Stockton on Tees **(Jane Edmends, Haleem Ghafoor)**
- Dentistry Review **(Healthwatch)**

**Scheduled items Frequency:**

- Domestic Abuse Steering Group Update (March and September) **(Sarah Bowman Abouna/Mandy McKinnon)**
- Alcohol Strategic Group Update (June and December) **(Sarah Bowman Abouna/Mandy McKinnon)**
- Integrated Mental Health Strategy Group (May and November) **(Sarah Bowman Abouna/Tanja Braun)**
- Tobacco Alliance Update (Usually June and December) **(Sarah Bowman Abouna/Mandy McKinnon)**
- SEND Strategic Action Plan (Usually May and November)
- Health Protection Collaborative Update (Usually January, April, July and October) **(Sarah Bowman/ Rob Miller)**
- Physical Activity Steering Group Update (May and November) **(Sarah Bowman Abouna)**