BCF Narrative 2023-25

Stockton-on Tees Health and Wellbeing Board

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

How have you gone about involving these stakeholders?

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)

Groups involving various stakeholders which have informed BCF Plans include:

- **Hartlepool and Stockton Discharge Group**
- **Adult Health and Wellbeing Partnership** - The Adults and Health Wellbeing Partnership which is chaired by the Director of Adult Social Care and Health, involves key partners from the Council, ICB, Health Services, Housing Sector, VCSE, Fire Services and Health Watch to meet regularly to identify, understand and address the needs of the population.
- **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. SBC, 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.

Sections on DFG and Equality and health and inequalities show how the BCF involves VCS and housing organisations strategically and operationally in preparing the plan.

Executive Summary

This should include:

- Priorities for 2023-25
- 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

The priorities of both the North East and North Cumbria (NENC) Health and Care Partnership strategy and the developing collective Tees Valley Place Plan, include aims and programmes to improve the quality of life for people through admission avoidance and investment in preventative services and tackling delays in discharges with improved outcomes.

Our partnership priorities include:

- Strengthening the provision of Home Care and Extra Care Housing and reducing the reliance on residential and nursing homes.
- Working with the care market to increase capacity and sustainability.
- Reducing the time people spend in hospital whose needs could be better met by access to social care.
- Developing shared solutions around housing and maximise the use of digital technology.
- Working to identify and support more people who are providing unpaid care.
- Improving joint discharge processes between health and social care.
- Scaling up intermediate care across all of our places and reducing the reliance on beds.
- Upskilling and scaling-up of social care staff and services across all of our places, enabling them to respond to the needs of local people and ensuring social care staff are valued as equals within the health and care system.
- Expand the range and uptake of 2 hour community response service to enable people to receive timely care in the right place.

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 2023-25 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 Covid19 pandemic, potential impact of flu and the impact of increased hospital discharges following restarting of elective activity across a range of hospital specialisms.

It is recognised that fundamentally we must maintain our focus on engaging with all our strategic partners to improve the quality of services across primary care, secondary health care, social care and the wider community.

The key changes to our plan this year will be the use of the BCF and Additional Discharge Funding to continue initiatives that support discharges to the right place with the right care at the right time. Our aim is particularly to reduce the reliance on use of beds and use the 'Home First' approach to promote an enhanced reablement model to enable more people to be discharged on pathway 1 and 2 with rehabilitation and reablement to optimise the chance of recovery.

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) which includes clinical triage and various schemes to support the care home sector. The Urgent 2-hour community response below also supports 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 timely 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. Utilising the BCF, well-established and robust systems are in place to support a Home First approach and getting people home in a timely manner.

Residential admissions - older adults whose long-term care needs are met by admission to residential or nursing care

The Discharge to Assess initiative remains in place and is continuously progressing along with intermediate care and rapid response services offers the opportunity for people to receive the care and time needed to maximise recovery and maintain independence, thereby reduce the need for home care support and avoid admission to long term residential nursing 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. We maintain relations and continued pathway improvement through forum and bespoke feedback session to ensure outcomes for people remains at the forefront of our minds.

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. We have completed workforce development for community engagement, sign posting and ordering low level equipment to focus on the holistic approach to Reablement giving every opportunity for people to remain at home when safe to do so.

Urgent 2-hour community response:

SBC are part of the 'Urgent and Emergency Care Managed Clinical Network' and local 'Tees Valley Urgent Community Response Group.'

SBC and health colleagues have agreed a range of BCF funded options available to support the urgent and emergency care clinical network, to reduce the pressure on NEAS, primary care and acute care.

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 and 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)

National Condition 1: 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 2023-25*
- *Approaches to joint/collaborative commissioning*
- *How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs .*

The BCF funds a range of 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-on-Tees.

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 continued service pressures, the Community Integrated Assessment Team (CIAT) 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. The service has now been in place with a Stockton-on-Tees footprint for over 3 years and continues to develop and mature. Integrated working and joint operational planning to support timely discharges.

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.

iSPA gives 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.

Continue investment is needed in the iSPA to ensure that there are sufficient coordination, resources and flexibility across health and social care to address future needs and emerging threats. Currently, proposals are being developed to move the location of iSPA to co-locate with front door services to Adult Social Care and wider health community services.

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.

National Condition 2

Use this section to describe how your area will meet BCF Objective 1: ***Enabling people to stay well, safe and independent at home for longer***

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- *Steps to personalise care and delivery asset based approaches*
- *Implementing joined up approaches to population health management and proactive care and how the schemes delivered through the BCF will support these approaches*
- *Multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake*
- *How work to support unpaid carers and deliver housing adaptations will support this objective*

A key system aim across Stockton-on-Tees and the Tees Valley is to continue to identify appropriate alternatives to a hospital admission through the use of more innovative service models and by better joining up the service offers available across primary, community and secondary care; including NHS 111 and our Ambulance Service provider.

We know from national and local evidence, and via the Fuller report, that people's care needs can often be best met outside of a hospital setting through integrated (neighbourhood) teams, where admissions can be avoided with the right care and support in place. We are stepping up capacity for out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, and in some cases, replace the need for admission, and in others facilitate people being able to safely leave hospital sooner.

Across Stockton-on-Tees and the wider Tees Valley we have already commenced and made great progress in the development and implementation of our Virtual Ward models. We now need to extend and accelerate the breadth of conditions and patients who can be supported, out of hospital, using this approach. Our Virtual Wards aim to provide our patient population with hospital standard care within their own home, helping us to:

- Prevent unplanned hospital admissions and delays in hospital discharges.
- Further reduce inequalities for people by ensuring all health and care needs are met through delivery of virtual frailty ward and virtual respiratory wards.
- Embed good commissioning practices in integrated health and social care.
- Improve outcomes and experiences for people admitted into the virtual wards.
- Make data and evidence the basis for policy development, good practice, and targeted improvement support.

The role of virtual wards is to 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, 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-on-Tees, work is underway to develop virtual wards for respiratory and frailty with the aim of achieving the goals set out above.

Urgent Community Response (UCR) is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care within two-hours and/or reablement care responses within two-days. They provide a person-centred approach to optimise independence and confidence, enable recovery and prevent a decline in functional ability. Services should adopt a 'no wrong door' ethos and work flexibly based on need, not diagnosis/condition.

Our Urgent Community Response (2-hour UCR) aims to provide urgent care to people in their homes (including care homes) which helps to avoid hospital admissions and enable people to live independently for longer. The service offers a high-quality multi-professional integrated response providing both intensive short-term hospital-level care at home or in a care home which:

- Reduce the risk of deconditioning, delirium and hospital-acquired infection.
- Improve hospital flow.
- Support older people to regain independence.
- Reduce demand for readmission and long-term support.

Close working between hospital, primary care teams, ambulance providers, community rehabilitation, and intermediate care and reablement services will ensure an efficient and sustainable integrated network of UCR in our locality.

Following the introduction of new Hospital Discharge Operational Guidance, discharge arrangements have been revised and re-energised. Previous arrangements have been enhanced and monitoring of all hospital discharges have been strengthened.

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' scheme and associated scheme.

The Home First scheme which commenced in November 2020 ensures people who need care receive it in the right setting. The 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.

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 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

As part of service re-design, the ICB aims to ensure that the key principles of personalisation are considered and embedded into new pathways including personalised care support plans, shared decision making and Patient Activation Measures (PAM).

Knowledge and opportunities will be shared across all relevant Tees Valley place portfolio teams.

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.

Block booked and Spot Purchased beds

The 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 predominantly as a case-by-case spot arrangement.

Rapid Response Home Care

The 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.

Social Care Protection Operational Group

In collaboration with SBC, NTH NHS Foundation Trust and TEWV NHS Foundation Trust, the 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.

Dementia Services

BCF funds dementia services to support People with Dementia (PWD) and their carers to empower them to live at home for as long and independent as possible. These include:

Livewell Dementia Hub (Hub)

The Hub works collaboratively with partner organisations to provide a single first point of contact for information about dementia and support that is available locally. The Hub provides a first level of information for people living with dementia and carers and can triage people's information and support needs. Where a person requires information and support beyond that offered by the Hub staff, the Hub will help people to get in-touch with more specialist services. This means that specialist (and often more expensive) services can focus on people needing them the most.

By bringing together a wide range of local organisations, the Hub also provides a venue for a number of different organisations to deliver services from, enabling people to access complementary services within the same venue or during the same visit. The services within the Hub include:

- Assessments by the Memory Clinics
- Cognitive Stimulation Therapy delivered by TEWV
- Up-to-date information
- Activity-based and peer support groups
- Awareness raising events, and
- Carers and professional education

Dementia Advisor Service

The Dementia Advisor Service offers specialist information and advice about dementia, and local support services. The Advisors aim to work with individuals from an early stage of their journey enabling them to undertake preventative work to ensure that following a diagnosis people with dementia and their families are enabled to develop the knowledge, skills and confidence required to maximise self-management and actively engage in their health and care. This includes:

- Helping people to identify, access and utilise existing health, social care and voluntary sector services that can help the person achieve their financial, emotional, social and health care goals
- Working with people to find solutions to the practical and emotional barriers that prevent them from accessing existing support services
- Making people aware of non-dementia specific community resources
- Ensuring carers, family and other people in the person's social network have the skills required to care for the person with dementia and ensure they are aware of how to access support in their own right. Encourage them to attend the carers education.
- Helping people to plan for the future as appropriate

Stockton Dementia Friendly Community Project

The Project aims to make Stockton-on-Tees proactively identifies what PWD and their carers needs. It explores what opportunities are available and then supports businesses

and organisations within in the community to create these opportunities and build community assets for PWD and their carers.

National Condition 2 (cont'd)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- Learning from 2022-23 such as
  - Where number of referrals did and did not meet expectations
  - Unmet demand, ie where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - Patterns of referrals and impact of work to reduce demand on bedded services – eg admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services

- Approach to estimating demand, assumptions made and gaps in provision identified
  - Where if anywhere have you estimated there will be gaps between the capacity and the expected demand?

- How have estimates of capacity and demand (including gaps in capacity? been taken on board and reflected in the wider BCF plans

Stockton on Tees Discharge Pathways

In Stockton on Tees, the overarching aim is to support people in the community and when a person is admitted and discharged from hospital, to get them back to their usual place of residence, reflecting the Hospital Discharge and Community Support Policy and our 'Home First' ethos.

In almost all cases the short-term intermediate care services/ staff who support people to remain in the community (step-up) and support people following discharge (step-down) are part of the same service/ staffing cohort. This is the case for domiciliary/ home-based care and bed-based care with the intermediate care beds also being used for both step-up and step-down. Generally, there isn't dedicated step-up or step-down staffing/ capacity (including beds) rather usage is based on demand. However, the vast majority of the short-term intermediate care demand (home and bed-based is following a discharge from hospital.

People going home with little to no support needs (Pathway 0) make up the largest proportion of discharges. There are several services available to support people with low level support needs, including the 5 Lamps Home from Hospital and the NTHFT Home but Not Alone services. Alongside these commissioned services, there are some charitable services who will support people with day-to-day activities. These services are ad-hoc and no formal commissioning or monitoring arrangements are in place.

Depending on the level of need, there are services available to people being discharged on Pathway 1, who need a little more help to recover at home. This includes Domiciliary Care

Providers and the Trust Rehabilitation Team who provide up to 4 weeks of support at home. Alongside these we also have a Home First service, Telecare, the Intensive Community Liaison Service and some condition specific healthcare services i.e. Community Respiratory Service.

We have a range of community beds which can be used for both step-up and step-down. In terms of Pathway 2 and 3 discharges there's no distinction to the way the beds are commissioned, and they can be used for either Pathway until the capacity has been used. There are 44 beds available at the Rosedale Centre, which is the core intermediate care facility commissioned on a recurring basis. Initially 22 of these beds were commissioned as Rehabilitation beds and 22 were Assessment beds, however there is an option to flex as needed and there is no longer an obvious split in the way the beds are used. In addition to this there is an option to use spot purchase beds when Rosedale beds are not available. The availability of spot purchase beds is dependent on a number of factors, including the local care home market, the needs of the individual, the wraparound supporting workforce and funding restrictions.

2022/23 Learning Points

Completing the capacity and demand requirements in 2022/23 formalised a process which has been taking place in Stockton since the COVID pandemic. Representatives from Adult Social Care and Health services work together and collaborate on a daily basis at ISPA, via a weekly meeting (Discharge group) and have regular meetings with the BCF Delivery group to explore pressures, agree resolutions and plan how best to cope with demand and capacity, this ensures the flow of patients continues despite any arising challenges. In times of high demand measures are put in place to alleviate these where possible, for example there is currently an increase to the core domiciliary care hours in place. We also use demand projections to inform discussions regarding future capacity, particularly in relation to homecare and beds.

We use a range of tools to support this, including:

- **LAS and CONTROCC** - SBC uses The Liquidlogic Adults' Social Care System (LAS) as its main case management system which went live in September 2021. The system is designed specifically for use by social workers and other local authority based professionals in their support of service users including carers. LAS interfaces with CONTROCC to provide a seamless process of managing contracts and budgets, making payments and collecting contributions
- **OPTICA** – hospital system being developed with the Trust to share information using a dynamic link to both the Trust and LA systems.
- **Power BI** – implemented in 2022, this on-line interactive tool is used to produce dynamic information from source systems automatically, so that users immediately have access to intelligence on the most up to date information. This is being rolled out to all teams as the range of reports are being converted from the old mostly static reports to this new way of working.
- **Capacity Tracker** – national on-line system that gives local intelligence on care providers in Stockton, including capacity and vacancy details by each provider, care home etc.

- **Activity reports** – existing range of reports that provide detailed information to managers – most of these are being transferred to the new Power BI tool on priority basis, e.g. ISPA report completed first, Team Activity report etc.
- **Complaints and compliments management** – regular report goes to Adults Services Committee to show the range, nature and trends of both compliments and complaints received, so that we are transparent with members about service delivery.
- **Liaison with independent providers** – regular weekly contact with all providers, regular provider forums allow detailed, consistent and comprehensive exchange of information and intelligence on both current issues and future developments.
- **Surge management** – 'Tees Valley Incident Command and Coordination Centre' call occurs on a daily basis, including Heads of Service for early intervention service along with health colleagues.
- **Hospital Discharge group** – regular weekly meeting with Trust, ICB and Local Authorities to identify current issues and trends and related problem resolution and options planning.

This combination of meetings, tools and information sharing monitors performance and expenditure and identifies gaps and pressures to respond to any demand and capacity issues. These tools and information sharing mechanisms produce our statutory returns and enable us to have a better understanding prior to making any operational and strategic decisions. They have also informed us that in comparison to 2021-22, 2022-23 saw an increase in the numbers of referrals coming into the Health and Social Care system, but also allowed us to break this down by area, pathway, function etc. However, both the current and previous BCF Capacity and Demand data collections show a one-dimensional view of capacity and demand, and do not consider any waiting lists or trends in waiting lists, and activity projections do not show whether patients have been discharged on the most appropriate pathways. This is hidden demand that we are not currently capturing. It was difficult to use this data alone to accurately identify any shortage in capacity or unmet demand. We did however use the data alongside the local intelligence detailed above to inform further discussion/understanding and action including:

- It appeared that there were far more people being discharged on pathway 3 than we would expect, and the Discharge to Assess Model (Professor John Bolton) suggests should be the case, although this model is based on aged 65+ and we tend to report on all ages. Further discussion identified that this was due to the way discharges are coded to each pathway, for example someone returning to a Care Home is currently coded as Pathway 3. The figures for the other pathways had similar anomalies, which are currently being investigated further.
- Services are not commissioned in such a way that it is straight forward to measure the capacity for a certain element of them. For example, the staff members who deliver rehabilitation services also deliver other services, and the services they provide are flexed depending on the demand. This may mean that it appears we have sufficient enough capacity to meet the demand, but that is because of this flexibility and overall there may not be enough capacity in the system.
- Within Stockton the actual activity for Community Beds in the last 6 months of 2022/23 far exceeded the predicted numbers. Work is ongoing to try to identify why, although we think there may be several reasons:

- Increased activity in the hospital (both Elective and Non-Elective), including a surge in demand over the winter months.
- Limited capacity in the domiciliary care market and increased pressure on discharge teams.
- Workforce issues (sickness, recruitment etc) and restricted admissions due to outbreaks in the Rosedale Centre resulted in more spot purchases
- There has potentially been an increase in step-up placements.
- There may be instances where it appears there is sufficient capacity within the system, but this may not be the case:
- There may be packages of care available, but not at the most popular times of the day (i.e. 9am calls)
- Dom Care providers cover different geographical locations within the town, if one provider has no capacity the other may not be able to cover this area
- The Rosedale Centre can accept a maximum of 3 admissions per day, therefore if this limit has been reached there may be capacity in the home which cannot be used.
- Care Homes have a limit of how many residents with 2-1 care needs they can admit due to staffing limitations.

This information has enabled us to negotiate and agree priorities to respond to the pressures identified – this could include discussing and agreeing alternative arrangements where demand cannot be met by the originally intended service.

These processes and tools allow us to keep a dynamic and up to date check on the capacity available, as well as the demand variation and the response to deal with this variation on a weekly basis, within the framework of the BCF and wider funding options.

2023/24 Approach to Capacity and Demand

As with last year, we have taken a joint approach to completing the Capacity and Demand information. This is necessary to ensure all Capacity and Demand is considered across the locality, however it also provides challenges, as to do this we require data from different information systems. This introduces the risk of missing some patients, double counting others and the systems are used to record information in very different ways. For this reason, we have made a number of assumptions when collecting the data, all of which have been documented in the assumptions section on the planning template. To project the demand over the coming year, we have applied a 3% uplift on previous activity.

Much of the low-level social support, including VCS, is provided by charity organisations and volunteers who support people on an ad-hoc basis. This includes helping with shopping, sorting bills and paperwork, cleaning and liaising with other services. There is no set time a person will receive this support and the commissioning of the services vary. Due to the nature of the of these services, most have no formal mechanisms in place to report how many people have been supported or for how long. Similarly, as many of these services use volunteers, the capacity can fluctuate quite significantly. We are not able to accurately report the demand for these services nor the capacity available to meet this demand.

When calculating the capacity of Care Home beds for reablement/rehabilitation we had to consider other factors as well as the actual number of available beds, including the workforce available to support people in the beds, and financial constraints. Because of this, the reported capacity does not include all available Care Home beds in Stockton.
This Capacity and Demand data collection does not include Mental Health data, as we do not currently collect this. We have initiated discussions to set up collection for this, however the data is not available for this planning submission. We do, however, have Mental Health representation in the weekly discharge discussions and are aware of the pressures faced. Addressing this gap will be taken forward via the discharge group and a task and finish group established with performance/ business intelligence representation.

Using Capacity and Demand to Inform BCF Plans

Existing systems and processes which are set up to manage capacity in response to the change in demand will continue and will develop further as needed. BCF plans for 2023/24 currently include extra capacity for pathway 1 discharges and a higher numbers of community beds, both based on the projections we have developed. A larger joint piece of work is underway to review our intermediate care pathways. Initial findings have shown that we have a higher than expected reliance on beds, and although a deeper dive into these patients is needed to determine if this was the most appropriate discharge pathway, discussions are also focussed on how we can get more people back home with support.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- Emergency hospital admissions following a fall for people over the age of 65
- The number of people aged 65 and over whose long term support needs were met by admission to residential and nursing care homes per 100,000 population

Falls response services are required in all systems for people who have fallen at home including care homes. We are therefore incorporating and building on the work in Enhanced Health In Care Homes (EHICH) and UCR in order that we can provide a preventative and reactive comprehensive and coordinated community-based falls response for Stockton-on-Tees and the Tees Valley.

This is to ensure people receive the right care in the right place at the right time, proving appropriate care to people in their own home. The proposal is to initiate a project to engage and consult with stakeholders to undertake a 3-stage process which will include scoping, mapping and reviewing what community falls services are currently available to support people who have fallen and those at risk of falling.

Following the conclusion of the phase one scoping stage, which includes a review of available digital data and discussions with stakeholders to identify relevant pathways and resources, phase 2 will be a mapping stage, plotting identified providers and pathways into services in order to understand the community falls offer across Stockton-on-Tees and the

Tees Valley and associated funding streams, review relevant data to develop a local picture of demand and responses from each locality and identify potential gaps and make recommendations for consideration.

BCF will support new schemes of work aligned in expanding the Falls response offer 7am - 7pm with an integrated pathway of response. This sees our Multidisciplinary Service being trained and educated in emergency falls response and will form part of working roster alongside health to give additionality and resilience to reducing number of people admitted hospital due to a fall. The scheme is in development, staff have been trained and the next steps are focussing on shadowing and competency development.

We acknowledge a recent upshift in our local data indicating an increase in people over 65 who needs are being met in a 24hr care environment than previous year. Following this we are looking at commissioning additional capacity within the acute trust as trusted assessors and will launch workshops and training with the focus of having the family/community support conversations before looking at commissioned services. Additional community therapy is being considered to promote additional rehabilitation to people in the community and negating the need for escalating care. The two proposals are:

Additional therapy

We are planning to commission additional therapy workforce to support the rehabilitation and recovery of patients discharged from the acute hospital into Intermediate Care pathway 2 beds as part of the current Discharge to Assess (D2A) pathway supporting a Home First approach. Due to the D2A pathway as a response to support hospital discharges, the demand for these beds has continued to rise. The additional workforce will provide therapy resource to reduce the need to stretch the existing resource and improve the flow through this pathway and to improve the outcome for patients returning to their preadmission functional level, reducing the risk of deconditioning and the need for long-term residential or nursing home. The proposal will also ensure that consistent therapy support can be provided to patients 7 days a week.

Trusted Assessors

We are also planning to commission 2 WTE additional B4 Trusted Assessors to work in North Tees Hospital to support the current team that triage, reassess, and rehabilitate patients who have been recommended a community bed upon discharge. The role of the Trusted Assessor would be to review the assessment document initially completed by ward staff to ensure it is a true representation of the patients' needs and that the discharge pathway is the most suitable. They would be supported by the Integrated Discharge Team to adopt a 'Home First' approach and be encouraged to explore all options available to support the patient's needs safely within their own home as a first option, therefore reducing the demand placed upon community beds. The post holders would have strong links with both health and social care colleagues to promote integrated working and a stream lined person centred approach, utilising the discharge to assess pathways.

National Condition 3

Use this section to describe how your area will meet BCF objective 2 : **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered 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, in line with the Government's hospital discharge and community support guidance
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow

Focussing on hospital discharge, care services are commissioned to ensure they can provide same day care, supporting safe and timely discharge form hospital into the community. We have funds set aside to trigger additional capacity when surges activity occurs, negating need for additional processes. It is noted that a certain period of extreme surge we do not have enough capacity commissioned at that time, however external variables such as unforeseen surge and staffing issues are the main causative factors. On reviewing average requirements across set time frames we remain in a positive position for capacity and demand for community IC beds and care at home.

Several community services such as Home First, Reablement and independent care market providers are in place to support care packages in persons own home ensuring they can be discharged to their usual place of residence. The collaborative commissioning approach between health, social care and independent marker ensures we have visibility of the market and can mobilise care responses timely. A key aspect of the joint working is commissioning by time critical responses, the care providers are set up to provide same day response and this achieves the highest through-flow of hospital beds we can achieve in this aspect of discharge planning.

We have instigated a hospital discharge intelligence work strand that is aiming to build and collate data sets with a primary focus on outcomes for people being discharged from hospital. The group is in its infancy, and we anticipate developing to a stage it delivers frequent, accurate and supportive information aligned to outcomes for people discharged from hospital.

We have utilised the additional discharge fund to commission several schemes to support hospital discharge. They include:

Tees Community Equipment Service (TCES)

Additional resources have been funded to enable TCES to increase the amount of same day delivery of assistive equipment from 30 to 40 Monday to Friday. The increased capacity allows a further 50 same day discharges to be facilitated per week.

Complex Discharge Coordinator

A coordinator within the hospital has been recruited to assist with complex discharge. It has demonstrated a reduction in Criteria to Reside, Length of Stay and cost post discharge.

Tees Mental Health Discharge Service

Delivered by Home Group, the Teesside Mental Health Hospital Discharge Service forms a pathway into the community from hospital, supporting people with serious mental illness to resettle in the community.

Increase Discharge to Assess hours

Delivered by Partner for Care and Five Lamps, the scheme ringfences additional 1000 hours care to call upon throughout the year to support discharge and use the 'Home First' Approach to support more patients to be discharged to usual place of residents.

Carer Service in Hospital

The scheme is delivered by SBC Adult Carers Service to provide practical support for carers looking after someone who is being discharged from hospital.

Additional Community Beds

Funding has been allocated to increase the number of placements of community beds to support hospital discharge.

Weekends/evenings discharges to care homes

Funding has been allocated to increase the number of care staff in care homes to cover weekends and evenings to support discharge during these periods to reduce LoS and delayed discharge.

Additional support for patients with complex mental health needs

We are commissioning a scheme to recruit a dedicated Social Worker to support patients with complex mental health needs both from acute trust and mental health trust beds to prevent delay in hospital discharge.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- Learning from 2022-23 such as
  - Where number of referrals did and did not meet expectations
  - Unmet demand, ie where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - Patterns of referrals and impact of work to reduce demand on bedded services – eg improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services

- Approach to estimating demand, assumptions made and gaps in provision identified
- Planned changes to your BCF as a result of this work

- Where if anywhere have you estimated there will be gaps between the capacity and the expected demand?
- How have estimates of capacity and demand including gaps in capacity been taken on board and reflected in the wider BCF plans

An overview of our rationale for both discharge from hospital and supporting people in the community is summarised on page 13.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metric

- Discharge to usual place of residence

Rationale and plan to support people being discharged to usual place of residence are summarised in National Condition 2.

We have an agreed strategic priority to support people to be discharged to their usual place of residence. There are a range of initiatives that have been put in place and enhanced to support this, they include:

- Home First – a multidisciplinary team that can deliver effective nursing and rehabilitation interventions during this initial period of up to 7 days to promote independence.
- Virtual wards – working closely with our health colleagues to provide a collaborative approach.
- Use of assistive technology solution to provide a better and more technologically advanced solution to support hospital discharge.
- Trusted assessors – support this function within the hospital setting to identify potential patients who will be able to return to their usual place of residence, who, once clinically able, can be prioritised.
- Increased TCES resource has provided additional capacity around same day deliveries, where the client is in a hospital setting.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

We continue to implement the High Impact Change Model for managing transfers of care and many examples of this are outlined in other sections of this template. In summary:

- Early discharge planning – the Integrated Coordination Centre, daily system calls and on-going internal work with Trust colleagues.
- Monitoring and responding to system demand and capacity – the reporting mechanisms and daily and weekly multi-agency meetings.
- Multi-disciplinary working - examples include our ISPA and Integrated Coordination Centre.

- Home first – our system aim wherever possible and established D2A processes.
- Flexible working patterns – increased weekend working by social care.
- Trusted assessment – in place to support and expedite discharges.
- Engagement and choice – examples include our carers in hospital support and staff engagement with patients and families to seek the best outcomes but manage expectations.
- Improved discharge to care homes – well established EHICH processes and Trusted Assessors.
- Housing and related services – services in place to support with needs patients may have on discharge.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the IBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

The Care Act introduced a national framework to determine whether a person has eligible needs and for the first time, the Act, ensured that family carers had the same rights to assessment and support as the people that they care for.

The Care Act introduced a legal duty to prevent, reduce and delay people's needs from worsening and confirmed that people must be supported at an early stage to prevent and reduce the likelihood of people ending up in crisis.

The Care Act 2014 places a duty on local authorities to promote an individual's "wellbeing". This means that they should always have a person's wellbeing in mind when making decisions about them or planning services.

In order to ensure duties under the Care Act are delivered there are a significant number of activities that are implemented to assure the quality of adult social care services including:-

- Survey Feedback Tees Safeguarding Adults Board Quality Assurance Framework
- Practice Month
- Annual Conversation
- Peer Review of Adult Safeguarding
- Continuous Professional Development
- Feedback from the Workforce
- Peer Discussions
- Review of Complaints and Compliments
- Celebrating Success

We are commissioning additional capacity in the Deprivation of Liberty services (DoLS) and Safeguarding Team to ensure the duties under the Care Act are being delivered.

Additional capacity for DoLS assessments

Th scheme aims to increase funding which will be managed by the DoLS team to support the extra activity in completing DoLS assessments for people admitted to a discharge to assess bed in a care home. Currently the team commissions the assessments through independent assessors when required. Since the implementation of the discharge to assess process the number of DoLS assessments requiring completion have increased. In the last financial year 293 applications for a DoLS authorisation were received for people in a discharge to assess

placement in a care home. These are extra assessments for the local authority to complete purely because of the discharge to assess process.

Additional Safeguarding Social Worker

This scheme aims to recruit one Social Worker to look at investigating Safeguarding Concerns and s42 enquiries around people being discharged from hospital during the discharge process and the initial stages of the placement in the care home. A safeguarding report for the period of 01/03/2022- 01/02/2023 evidenced that out of 697 clients who were discharged from hospital to a care home in that period, 167 also had contact with Adult Safeguarding during the same period. The use of discharge to assess beds has impacted on the number of safeguarding concerns and has resulted in care homes being discussed under measures used by the Teesside Safeguarding Adults Board (TSAB) to address serious concerns in care homes (RASC). This dedicated worker will be able to deal with concerns in a more effective and timely manner. Building up a positive relationship with wards and care homes and thus helping to improve the overall discharge process.

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, enabling them to achieve their identified outcomes. 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 supports (i.e. subject specific workshops). The service implements the care act duties through the administering of carers assessments, support planning and carers personal budgets alongside providing information advice and guidance. They also provide the opportunity for carers to undertake self-assessment, something that has recently been further developed alongside carers to make it easily accessible. 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 the carers personal budgets to promote the carers overall wellbeing. Using prepaid cards to facilitate budgets and enable fast payment and choice of usage. The budgets are designed to enable carers to meet their wellbeing needs or provide a break from the caring role in a way that is meaningful to the carer. Whether this be an actual physical break or something that represents time out for that individual such as investment in a hobby or relaxation opportunity.

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 provision of free of charge sitting service, named Time Out Support Service, utilising paid support workers to enable carers to feel comfortable and reassured whilst taking a short break. There are also opportunities for carers to connect with each other directly to provide small scale peer support and the development of supportive relationships.

The service has been utilising different ways to engage with carers both face to face and virtually. We have developed a carers walking group and also now publish a fortnightly email bulletin and quarterly paper newsletter to ensure our communication with carers remains as timely and thorough as possible. The service runs various social media channels and uses all of these methods to engage with and develop support in line with what carers tell us they want and need. Providing an annual carers consultation event to further ensure we are fulfilling our care act duties and also engaging with hard-to-reach groups to co-produce information that is accessible. Other services include:

- Carers Assessment and Support Planning
- Carers Personal Budgets
- Carers Register
- Online and face to face peer support (1:1 and group)
- Carers walking group
- Awareness and training workshops
- Carers Emergency Cards
- Carers Connect
- Support for carers in current employment
- Information, advice, and signposting

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 strategic approach to using housing support including DFG funding that supports independence at home?

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 by Foundations the Council is currently exploring further ways to support residents using RRO powers, for example:

- Working with Registered Providers and Private Landlords to support them to make their own DFG applications.
- Looking at increasing the £30,000 current maximum grant award.
- Looking at introducing a policy for rapidly progressing and highly debilitating conditions where residents are still able to work in their early stages of diagnosis – current policy would make them ineligible because of their income.
- Including assistive technology within DFG Policy.
- Allowing DFG's on two properties where a child's residency is shared equally with both parents.

However this needs to go through the Council's process for ratification by Cabinet, which we expect to do within the next 6 months.

During 2022/23 Stockton Council delivered 437 adaptations 21 more than 2021/22. Of the 437 adaptations, 153 were DFG's, 208 Stairlift loans and 76 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. Following a recent Directorate restructure the Housing and a Fairer Stockton-on-Tees Team has recently moved into 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 our current waiting list.

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.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

We are a Unitary Authority and based on 2022/2023:

- Equipment Loan Scheme: = £863,222
  - Stairlift Loans – 208 delivered = £647,956 (round to nearest £)
  - Ramp Loans – 76 Delivered = £215,266 (round to nearest £)
- Top Up Loan Scheme: = £9,638
  - Homeowner DFG Top Up Loan – 1 delivered = £9,638 (round to nearest £)
  - Homeowner DFG Loan
  - Tenant DFG Loan

Equality and health inequalities.

How will the plan contribute to reducing health inequalities and disparities for the local population, taking into account of people with protected characteristics? This should include:

- *Changes from previous BCF plan*

- *How equality impacts of the local BCF plan have been considered*
- *How these inequalities are being addressed through the BCF plan and BCF funded services*
- *Changes to local priorities related to health inequality and equality and how activities in the document will address these*
- *Any actions moving forward that can contribute to reducing these differences in outcomes*
- *How priorities and Operational Guidelines regarding health inequalities as well as local authorities' priorities under the Equality Act and NHS actions are in line with Core20PLUS5*

SBC has published a Fairer Stockton-on-Tees 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.

The Fairer Stockton-on-Tees (FSOT) team have also worked with colleagues and partners on a range of priorities around the cost of living work that have been identified via the direct feedback from our local communities and service users. These efforts were concentrated into six working groups comprising representatives from across Council services and key partner organisations to address the most pressing issues and needs in that area. In addition in response to the ongoing Cost of Living issues, SBC has also introduced a number of initiatives (for example the Cost-of-Living on-line HUB / Warm Spaces, Help and support booklet etc.) to support the boroughs residents. The six groups are:

Energy Crisis - Ensuring key energy and utility advice, help and support is identified, promoted and available across Council and partner services. This group also monitors Warm Spaces in Stockton-on-Tees.

Food Crisis - Food banks, community pantries and eco-shops experienced significant increases in demand. This group worked in partnership with the Stockton Food Power Network to ensure activity and resources are coordinated to resolve shortages and boost resilience in the longer-term.

Corporate Social Responsibility - Corporate social responsibility (CSR) describes how organisations consider the economic, social and environmental impacts of how they work. It can provide real benefits for residents and community groups while making the most of what businesses and organisations can offer. This group is working to develop and coordinate a Borough-wide approach to CSR that reflects the values and culture of the Council.

Child Poverty - Following a recent scrutiny review, plans are developing to help tackle child poverty in Stockton-on-Tees. Proposals include increasing the take-up of free school meals, improving access to laptops, community support schemes and a family poverty profile to ensure support is targeted where it is needed most. This stream of work includes the Holidays are Fun (HAF) programme and is exploring the possibility of a Child Poverty Fund.

Employee Support and Upskilling - As a large employer, we know the cost of living will have impacted our staff in the same ways that our residents are experiencing therefore we have worked to make sure all staff are aware of all the support and benefits that are on

offer to them as an employee of the Council. This also included a video to support our staff when helping our residents.

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 Inequ

Health inequalities Tees Valley Overview.

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 Age UK Teesside, 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. The project continues to deliver well against the key performance indicators and targets. The service has successfully

adapted to local and national demands since the project started in 2016 and continues to provide a valuable support service. Within the current economic climate, the social groups delivered as part of the service continue to provide a consistently warm, safe, welcoming environment for vulnerable clients to engage in meaningful activities.

These groups also allow for further signposting into additional support services when needed. The befriending service offers supported hand holding into neighbourhood social groups and wider support services, which is particularly important for the socially isolated and those with long term conditions, who may lack the confidence to engage with support groups.

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. By supporting vulnerable clients in the community, and building positive relationships to reduce loneliness and isolation, the scheme will assist in meeting the BCF metric of Reduction in admissions to permanent residential care.