Live Well South Tees Board

Thursday 9th December, 2021

Please note that this meeting will be held at Redcar and Cleveland Leisure and Community Heart.

at 2.00 pm on
Thursday 9th December, 2021

	Agenda Item	Priority	Time
1.	**Welcome and introductions** *Cllr Mary Lanigan / Elected Mayor Andy Preston*		
2.	**Apologies for Absence** *Cllr Mary Lanigan / Cllr Dorothy Davison*		
3.	**Declarations of Interest** *Cllr Mary Lanigan / Elected Mayor Andy Preston*		
4.	**Minutes- Live Well South Tees Board - 30 September 2021** (Pages 3 - 6) *Cllr Mary Lanigan / Elected Mayor Andy Preston*		
5.	**TSAB Annual Report 2020/21 and TSAB Strategic Plan 2021/22** *Darren Best, Independent Chair, Teeswide Safeguarding Adults Board* https://www.tsab.org.uk/wp-content/uploads/2021/11/Final-Annual-Report-2020-21-1.pdf www.tsab.org.uk/wp-content/uploads/2021/05/Strategic-Business-21-22-Final.pdf	1,2,3	

LiveWell SOUTH TEES

6.	**Future Model of Community Mental Health Services** (Pages 7 - 24) *Maxine Crutwell, Tees, Esk and Wear Valleys NHS Foundation Trust*	1,2,3	
7.	**Better Care Fund Planning Submissions 2021/22** (Pages 25 - 40) *Kathryn Warnock, South Tees Integration Programme Manager*	1,2,3	
8.	**Integrated Care System Update** *Dave Gallagher and John Sampson*	1,2,3	
9.	**Health and Wellbeing Executive Chair's Assurance Report** (Pages 41 - 50) *Dr Ali Tahmassebi, Chair of Health and Wellbeing Executive*	1,2,3	

Date and time of next meeting
Thursday 17th March 2022 - 3pm till 5pm

Priority 1 – Inequalities
Priority 2 – Integration
Priority 3 – Information and Intelligence

30 September 2021

LIVE WELL SOUTH TEES BOARD

A meeting of the Live Well South Tees Board was held on 30 September 2021 at Redcar & Cleveland Leisure and Community Heart.

PRESENT Chair: Councillor M Lanigan;
Councillors: S Kay; L Westbury, M Ovens
C Blair, D Gardner, M Milen, A Preston, E Scollay, K Warnock, K Boulton L Bosomworth, M Anderson, M Adams, M Davies (SUB)

APOLOGIES FOR ABSENCE were submitted on behalf Councillors: Barnes, Hellaoui, Thompson and S Butcher, P Rice, J Walker, J Lowe, R Harrison.

DECLARATIONS OF INTEREST

None Declared

5. **MINUTES**

AGREED that the minutes of the meeting held on 8 July 2021 be confirmed and signed by the Chair as a correct record.

6. **HEALTHWATCH UPDATE**

The Project Lead for Healthwatch South Tees presented a report updating the Live Well South Tees Board with the work that had been undertaken by Healthwatch South Tees throughout the Covid-19 pandemic.

As part of the ensuing discussions, the following comments were made:

- Evidence suggests that some children and young people's mental health and wellbeing has been substantially impacted due to and during the pandemic.
- Members discussed the ongoing difficulties on getting face to face appointments with GP's especially in East Cleveland and given the health situation in this area this is something that needs to be kept a very close eye on, it desperately need an improvement.
- Each GP runs separately, it's been difficult to speak with GP's as a whole and each one is run differently, however, GP's should be offering face to face appointments. There is a meeting taking place next week with the PCN's to discuss this issue. Healthwatch are trying to be creative on how to combat the situation.
- Digital exclusion is still happening in all areas. Community champions are being utilised to reach out to charities etc, Age UK have a project called Digital Explorer who do home visits to help those struggling to get GP appointments by teaching them to use

devices.

- Difficulties in contacting GPs for appointments which is leading to a high contact rate to Healthwatch for a range of services.
- Getting GPs to attend care homes during the day is becoming increasingly difficult
- Cleveland Police have an engagement team which would benefit from the community champions.

:- Noted.

AGREED: that L Westbury, L Bosomworth and C Blair meet to discuss DNR and End of Life and report back at the next meeting.

7. **YOU'VE GOT THIS**

The Director of the You’ve Got This project was present at the meeting to inform Members of the work undertaken by the programme designed to change societal attitudes toward physical fitness.

As part of the ensuing discussions, the following comments were made:-

- One of 12 pilot projects funded by Sport England and is active across the country, The programme was designed to take a system level approach to build a community and a culture in which physical activity was valued. An active population is central to our climate ambitions. It’s also a key part of our economic ambitions.
- There are leaders at all levels of the system who have a role to play in influencing change.
- Partners are working together to design and deliver the programme, whilst minimising any competition.
- The funding doesn’t come in a single sum so currently preparing for the next stage of the program, a series of work is being looked at, working with health professionals to build this physical activity into social prescribing

NOTED.

8. **HEALTH INEQUALITIES IMPACT ASSESSMENT**

The Joint Director of Public Health for Middlesbrough and Redcar & Cleveland was present at the meeting to provide and update on Health Inequalities, Assessing Impact to Inform Action

As part of the ensuing discussions, the following comments were made:-

- The population intervention triangle is where services are looked at along with communities and policy. The intervention of the policy element is to ensure that all policies in partner organisation in health and wellbeing boards consider policies more systematically

to understand the impact on health and equalities and do something about that. Recommendation to adopt the health and equalities impact assessment and public health south tees will support partners with this.

- Routes to work scheme will no longer be running within the next few months, this has worked for a cohort of people that need additional support. If this is believed to be a valuable service a collective conversation needs to happen. The best way to get young people into work is ensuring their parents are working.
- Core of people that are not able to work, however, there are loads of opportunities available for unskilled workers but there is no transport to these businesses. Need to find a way of getting buses or flexi buses to be paid for to get people to work. Transport is critical for mental and public health.
- Health impact assessment is a really good opportunity for the board to do something tangible and meaningful. What is being suggested is a set of considerations which us as organisations systematically go through whenever we make decisions.

9. **HEALTH AND WELLBEING EXECUTIVE CHAIR'S REPORT**

The Chair of the Health and Wellbeing Executive presented a report and provided assurance that the Health and Wellbeing Executive was fulfilling its statutory obligations. An update was provided on progress with the delivery of the Board's vision and priorities**: - NOTED.**

10. **DATE AND TIME OF NEXT MEETING**

The Chair advised that the next meeting would take place on Thursday 9 December 2021 at 3pm at Redcar & Cleveland Leisure and Community Heart.

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LiveWell SOUTH TEES

To:	Live Well South Tees Health and Wellbeing Board	Date:	December 2021
From:	Tees Esk and Wear Valleys NHS Foundation Trust	Agenda:	Item 6
Purpose of the Item	Update on the Community Mental Health Framework Transformation for Middlesbrough and Redcar & Cleveland and development of operational model		
Summary of Recommendations	• Seeks support for the implementation of the model as a collaborative partnership for Middlesbrough and Redcar & Cleveland		

1 PURPOSE OF THE REPORT

1.1. To provide South Tees Health and Wellbeing Board (HWB) with.

- An update on the community mental health Transformation framework and development of operational model
- Seeks support for the implementation of the model as a collaborative partnership for Middlesbrough and Redcar & Cleveland

2 BACKGROUND

NHS England set out in the long term plan (LTP) its ambition by 2023/24:

> *'New integrated community models for adults with Severe Mental Illness (including care for people with eating disorders, mental health rehabilitation needs and a personality disorder diagnosis) spanning both community care provision and also dedicated services will ensure at least 370,000 adults and older adults per year will have greater choice and control over their care, and are supported to live well in their communities.'*

The Community Mental Health Framework (2019) set out its expectations for how and why this ambition could be delivered:

The **aim** of framework is:

- To deliver a new mental health community based offer
  - Redesign and reorganise core community mental health teams which are **placed based.** (*sound clinical governance is critical to successful implementation)*
  - Create a **core mental health service** which is aligned with **primary care networks and voluntary sector organisations** whereby dedicated services and functions will plug in.

Principles of the framework include:

- **Co-production**: active participants which lead and own the design for future services
- **Inclusivity** - No wrong door
- **Collaboration**: working as a system and building the infrastructure with existing services
- **Person centred care**: Care is centred around individual needs
  - Care is **proactive** not reactive
- Assessment is collaborative with community services and not repeated
- Community design which addresses **health inequalities** and **social determinants**

Approach: Step 1 focuses upon the core operational mental health model and discusses the visioning event which aimed to propose a visual operational model which is:

- more accessible to local communities,

- works collaboratively as a system (*collaborative pathways)*
- integrated with primary care and voluntary care sector services
- Avoid patients falling between services
- Focus upon physical health care as well as mental health

3	**RECOMMENDATIONS**
3.1	That Live Well South Tees Health and Wellbeing Board: • Seeks support for the implementation of the model as a collaborative partnership for Middlesbrough and Redcar & Cleveland

4	**BACKGROUND PAPERS**

Contact Officer Shaun Mayo, Head of Service for Older People and Adult Mental Health Teesside: shaunmayo@nhs.net

Working collectively to review the mental health system

NHS ENGLAND: TEES VALLEY

Background on Community Mental Health Transformation

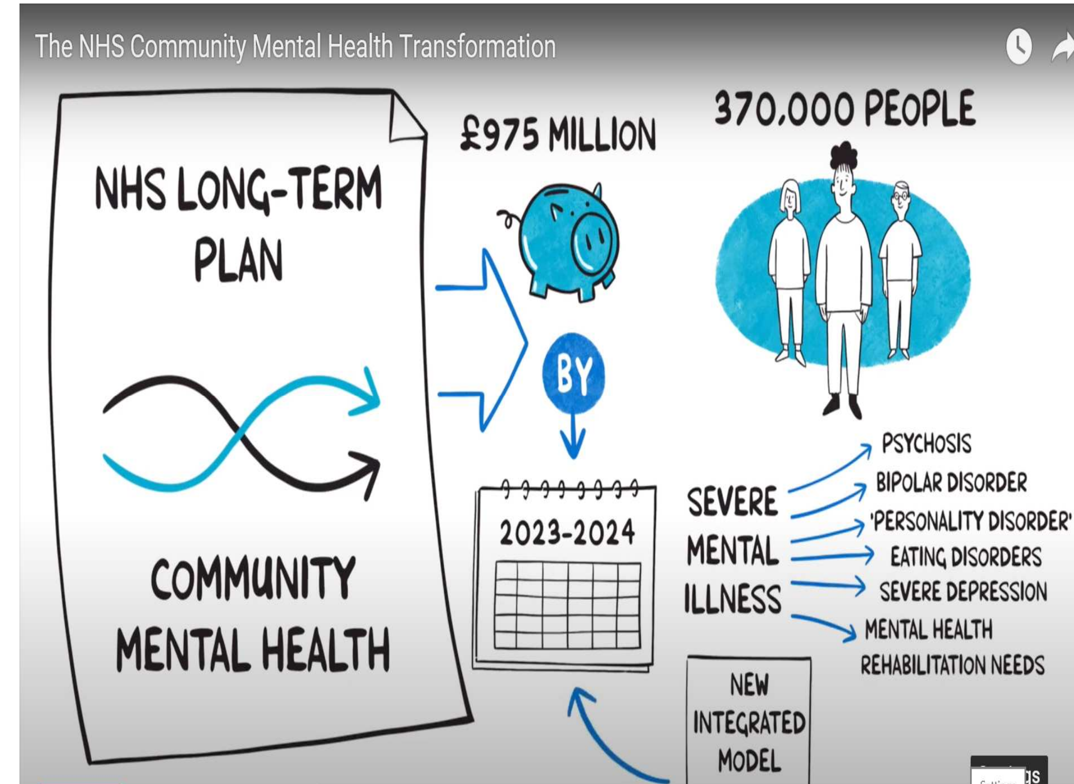
ore aims of Community Transformation

ackground:

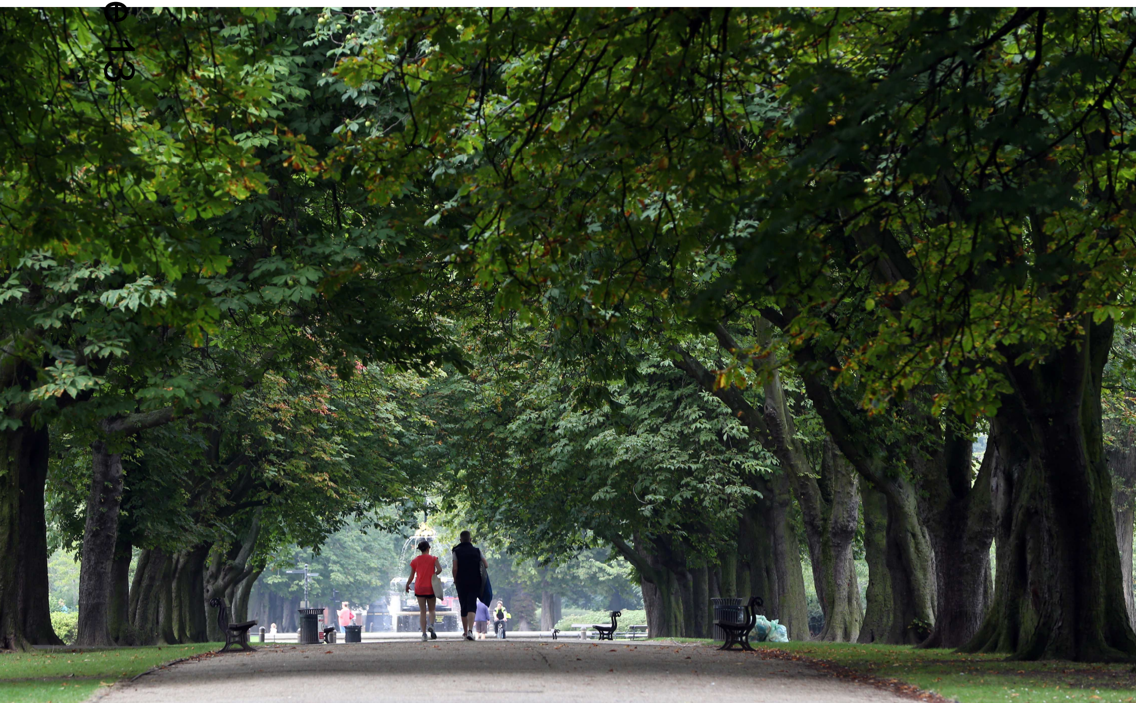
Driven by NHS England long term plan offering significant investment to enable those with severe mental health illness better access to integrated primary and community mental health care

Move from fragmented silo working to integrated, holistic, person-centered care model

Services and care pathways should be co produced with service users, carers and local communities.



What has been happening?



Healthwatch findings

Purpose of the report:

- **Understand each of the five local communities' need's:** what keeps people well and how communities would like to access mental health services in each area.
- **Establish a baseline** of what local people's knowledge of current services are and your expectations of mental health services.
- Enable local communities to have **greater choice** and control over their care, and to live well within each community.
- Develop **localised place-based** action plans that are held collaboratively as partners to meet the needs of local populations

- **Better communication** to the public of what is available in terms of wellbeing support.
- **Awareness raising** in communities to reduce the stigma of mental health.
- **Easier access** through local community venues or supporting transport needs.
- **Greater accessibility** for those who face physical and mental health challenges.
- Provision of **more creative activity**, exercise, and social activity groups.
- **Shorter waiting lists**.
- **Longer therapy pathways** – for example more than 6 sessions.
- **Greater exploration of therapies** rather than medication.
- More **empathy, understanding, respect and awareness** of mental health conditions.
- **Supporting those who have caring responsibilities**, to attend wellbeing sessions themselves: care for the carer.

Area			
Darlington	Men (over 18)	Parent Carers and Carers (over 18)	Young people aged 16 to 25 in transition from child to adult mental health services
Hartlepool	Deaf community	Blind and Visually Impaired	Older People
			LGBT
South Tees	Carers	Visually Impaired	Refugees and Asylum Seekers
	Ethnic Minority groups (2)		Older People
Stockton on Tees	People with a learning difficulty / disability	Substance misuse	Carers

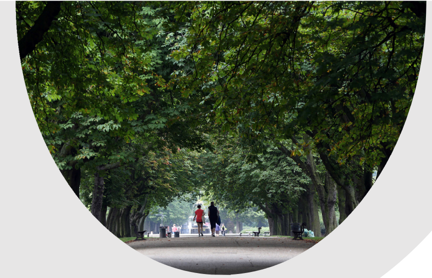
healthwatch

900 people engaged in consultation across the Tees Valley

Staff and service user/ carer led design

April 2021	May 2021	June 2021	July 2021	August 2021	Sep 2021	Oct 2021
Funding awarded	Shadowing teams	Staff voice network	Staff engagement	Volunteers map patient journeys	GP workshops	TEWV Redesign event
Governance structure established	Enhanced Psychology Provision	External workshops held	Staff visioning/ designs	Healthwatch go live	Service user and carer workshops	Development of Community Navigator Roles (VCS)
PCN Workforce implemented	Recruited 17 volunteers from Teesside University	Healthwatch engagement	Continue to shadow teams	Engagement with Mental Health forums	End of Healthwatch engagement	Introduction of Co-Production / Peer Lead role for CMHF
£600,000 resilience funding to VCS	Engagement with Mental Health forums	Engagement with Mental Health forums	Engagement with Mental Health forums		Recruited lived experiences roles to the board	
Delivered external stakeholder workshops					Patient stories and production of short film	

Information and mapping phase 1



Design Event

Principles:
ept each other's assessments.
e do not refuse a referral

Assessment, triage, support and advice

Intervention and treatment

Getting advice

Getting Help

Getting more help

al community support

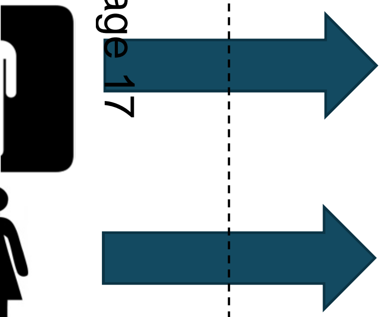
Primary Care networks

aries/ leisure centres

s/ recreation

ducation

s of worship



ily/Friends

/Colleagues

e support/ self help

cial Media

Aligned by PCNs

Primary Care Network Mental Health Team
Based in GP surgeries

Community Hub
Senior clinical staff including peers and community navigators.

Co-located with VCS and LA

Physical health Review offer/ medication

Treatment and Intervention Services

One team per locality

EIP

ADHD/ ASD

Personality & Relational

MHSOP & Dementia Ax

Rehab

Eating Disorders

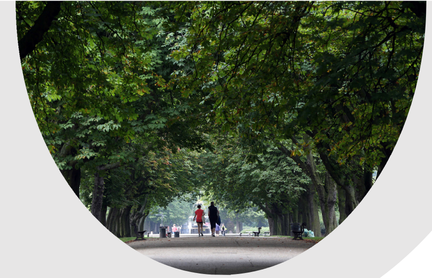
Perinatal

SUPPORTED BY NAVIGATORS

System one recording

CITO recording

PCN Pilot and developments



Tees, Esk and Wear Valleys
NHS Foundation Trust

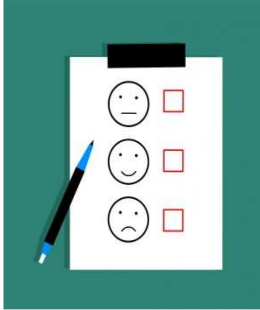
PCN Mental Health Practitioners

- 1 Full time mental practitioner in most PCNs.
- Practitioners are providing 20 minute appointments to 12 patients a day, 54 patients per week.
- Over 2000 appointments per year in each PCN
- Across Teesside 4,935 appointments have been facilitated between end of June-end October.

PCN Mental Health Practitioners

- Upskilling all the current staff to have an NMP qualification. To improve patient access to treatment and review of the treatment.
- Patients' attendance at appointments is good. The DNA rate varied from 7% - 19% between PCNs. The average DNA rate is 15%.
- The majority of patients are being contained within primary care services with intervention from the practitioners, social prescribers, IAPT and other VCS organisations.
- Now working alongside PCN Clinical Directors to enhance service offer based upon local population needs

Patient Feedback



Tees, Esk and Wear Valleys NHS Foundation Trust

Patient feedback is very positive and FFT patient satisfactions rates are between 95.83%-100%. All comments on the surveys are very positive.

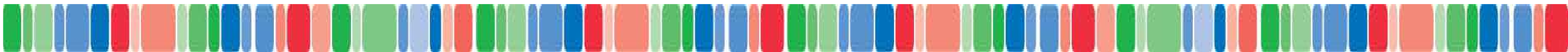
In the past when speaking to others regarding my mental health, I often felt dismissed and misunderstood, quite often leaving me feeling worse than before seeking help. However with this new service I felt listened to, properly understood and I actually feel some progress is being made with my issues for the first time in many years. The mental health nurse I spoke to was phenomenal, making me feel like some actually cared and that there was finally hope and light at the end of the tunnel. I am incredibly happy with this new service and would very much like to see it continue in this way.

Spoke to a highly competent, professional, caring individual – who was obviously well qualified and an outstanding example of her profession.

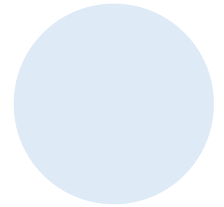
Nurse very professional, empathic and non-judgemental.

Fantastic, couldn't have had a more respectful, supportive person. Wonderful caring person

Very helpful call I felt so much better and positive in myself after. She couldn't of been more helpful



Next steps



Moving into year 2

- Sign off internally and externally to progress the model
- Working groups to be established for each area at place based for community hub model
- Co production of services through the introduction of Teesside Peer Led role
- Expansion of the PCN workforce

Closing comments

tewv.tvcommunitytransformation@nhs.net

LiveWell SOUTH TEES

To:	Live Well South Tees Health and Wellbeing Board	Date:	December 2021
From:	Kathryn Warnock	Agenda:	Item 7
Purpose of the Item	To seek formal approval from the Board of the 2021/22 Better Care Fund (BCF) Plans for Middlesbrough and Redcar & Cleveland		
Summary of Recommendations	Board members are asked to a) Note the national BCF planning requirements, conditions and metrics b) Review and endorse the BCF Plans submitted to NHS England		

1 PURPOSE OF THE REPORT

1.1. To seek formal approval from the Board of the 2021/22 Better Care Fund (BCF) Plans for Middlesbrough and Redcar & Cleveland.

2 BACKGROUND

2.1 The BCF Planning requirements for 2021/22 were issued nationally on 30th September 2021. Each Health and Wellbeing Board locality must complete:

a) a planning template which confirms how the BCF will be spent, that national conditions are met and ambitions and plans for performance against BCF metrics
b) an accompanying narrative template which outlines priorities, engagement and governance arrangements.

The four national conditions that all BCF plans must meet to be approved are:

- A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board.
- NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.
- Invest in NHS commissioned out-of-hospital services.
- Plan for improving outcomes for people being discharged from hospital

The BCF Policy Framework sets national metrics that must be included in BCF plans in 2021-22. This includes two existing metrics:

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

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

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

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

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

2.2 South Tees BCF Implementation and Monitoring Group worked together to draft the narrative and planning templates. They were submitted to our local Better Care Manager for initial review and feedback on 19th October, as recommended nationally. These draft templates were also reviewed by the Health and Wellbeing Executive on 2nd November.

The feedback was positive with only a few minor points highlighted. We updated the templates in response and the plans were endorsed by the South Tees Executive Governance Board and signed off by delegated officers on behalf of the Health and Wellbeing Board. The plans were submitted to NHS England by the deadline of 16th November 2021.

2.3 We are confident that our plans meet the national conditions and will contribute to delivery of the metrics, and we present them for formal approval by the Board.

Plans cannot be formally approved until Health and Wellbeing Board endorsement has been confirmed. Once that is in place, we hope to receive approval letters giving formal permission to spend from 11th January 2022. It is noted that three quarters of the financial year will have passed by that date.

3 RECOMMENDATIONS

3.1 That Live Well South Tees Health and Wellbeing Board approve the Better Care Fund plans for Middlesbrough and Redcar & Cleveland

4 BACKGROUND PAPERS

Attached as Appendices are the BCF Planning and Narrative templates for Middlesbrough and Redcar & Cleveland.

Contact Officer
Kathryn Warnock
Chair of the South Tees BCF Implementation and Monitoring Group

Health and Wellbeing Board

Middlesbrough (Live Well South Tees Board)

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

How have you gone about involving these stakeholders?

Our BCF plans have been developed collectively over the past years through regular meetings between CCG 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 CCG and Local Authority.

In South Tees (Middlesbrough and Redcar & Cleveland) 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 in South Tees Hospitals NHS Foundation Trust as well as local Voluntary Development Agencies.

Many of our other schemes have been developed to support care homes, taking on board their feedback and needs. Middlesbrough Council have regular care home forums and engage frequently with care home and domiciliary care providers to identify their needs and pressures.

The South Tees Health and Wellbeing Executive has the opportunity to review and input into our BCF plans. This Executive is a multiagency meeting with representatives from both acute provider Trusts, housing associations, GP practices, Voluntary Development Agencies and Healthwatch as well as both Local Authorities and the CCG.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The 'South Integrated Care Partnership', which is one of 4 ICPs within the Cumbria and North East Integrated Care System, has collectively agreed system objectives.

The members of the South ICP include Tees Valley CCG, 4 NHS Foundation Trusts, the 5 Local Authorities across the Tees Valley and North East Ambulance Service.

Our ICP objectives are:

- To ensure our population has access to the best possible care through the system wide delivery of a joint programme of hospital services consolidation and transformation – our clinical strategy, including mental health care and services for those with Learning Disabilities
- To improve our population's health, wealth and wellbeing through increased use of Population Health Management approaches, more targeted prevention activities and increased application of personalised care
- To ensure optimal use of resources for patient pathways through increasing local integration at place to support more integrated out of hospital services based around communities, aiding our financial recovery and driving service sustainability
- To attract and retain a skilled workforce across clinical networks – to address our current workforce pressures.

Our Better Care Fund plan supports the local and regional aims and outcomes. Our priorities for 2021-22 are aligned to the objectives above and more specially to the BCF and Ageing Well principles. There is also a focus on maintaining sustainable services with the pressures caused by the on-going covid-19 pandemic.

The Ageing Well programme is a blueprint for attenuating rising health service demand to support older people with frailty in their communities. It promotes healthier ageing and begins to address inequalities through population health management. In providing fuel for the journey to age equality, successful implementation will make better use of public and local community assets. Ensuring parallel development and implementation of both BCF Plans and the Ageing Well programme priorities is critical to ensure maximum impact of the available resource. This means better use of health and care services including hospitals and better outcomes for older people.

BCF Metrics:

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 services funded by the BCF to support this, for example additional rapid response, front of house services in the Acute Hospital, including a Frailty Co-ordination team, prevention initiatives and our Single Point of Access. These will be complemented by the urgent community response team which is being implemented through the use of Ageing Well funding (see below).

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. Please see the Supporting Discharge section below for details and also this embedded update provided by colleagues at South Tees Hospitals NHS Foundation Trust:

STHFT Update for BCF Plans.docx

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

Discharge to Assess initiative and our intermediate care and rapid response services offer the opportunity for the individual to receive the care and time needed to maximise recovery, The maintain independence and avoid admission to long term residential and nursing care if possible.

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, an expanded reablement team and overnight planned care.

Assistive Technology : Our dedicated Assistive Technology Assessor's work closely with Health & Social Care and the community. Supporting residents of Middlesbrough, they carry out holistic assessments providing essential equipment within the resident's home to enable them to remain safe and independent which supports in the reduction of hospital admissions. Working closely with our Hospital Social Work team and A & E therapies, they support with discharge planning and follow up once a resident has returned home from A & E. Yearly reviews are undertaken to ensure that equipment installed is still meeting their needs and also monitor 'frequent fallers' on a monthly basis offering extra help and support to aid in the reduction of falls.

Being part of Middlesbrough's prevention hub, assessors are able to support residents with their independence, referrals are speedily made onto other services such as our local home improvement agency, Connect service which supports the prevention of readmission.

Staying Included : Our Staying Included service supports Middlesbrough residents to improve their health, wellbeing and social welfare by connecting people to community groups and statutory services for practical and emotional support. By enabling individuals to increase their physical activity, through supporting mental wellbeing and helping people out of social isolation, the service supports a reduction in admissions to permanent residential care, helps reduce emergency hospital admissions and to prevent re-admissions.

Throughout and beyond lockdown, the Staying Included team has also provided welfare calls to clients, providing advice, support and sign-posting across a broad spectrum. Initially it was imperative to link vulnerable individuals to essential services to ensure basic needs and health requirements were being met. This included helping people arrange medication deliveries, ensuring that essential utility bills could be paid and that food could be safely obtained. Alongside linking into practical service set up in response to Covid-19, this included the Help Boro Portal and NHS Food Parcels.

In addition signposting and joint working around more complex issues has provided positive outcomes for people and in essence provided an early intervention to prevent people reaching a point of crisis and requiring critical care and hospital admission.

Ageing Well priorities:

Urgent 2 hour community response - *increase the capacity of intermediate care services to deliver a 2-hour response to those in crisis at home and 2-day response for those needing rehabilitation to avoid or following a hospital admission*
Existing BCF funded services which support this include our rapid response CHESS service offered to all South Tees Care Homes, general rapid response services and our intermediate care services.

This will be a priority for our system using Ageing Well funding to develop and expand an Urgent Community Response Team across the Middlesbrough and Redcar & Cleveland localities to provide a superior alternative to hospital admission in the event of a frailty crisis in the community. The aim is to develop a 24 hour, 7 days per week enhanced level of health and care framework which will ensure more patients are discharged from hospital sooner, and to ensure that those patients who are at high risk of admission into hospital will be able to be better supported in their own homes around the clock.

Our part BCF funded Single Point of Access will play a pivotal role in this.

Enhanced Health in Care Homes:
Now part of the Ageing Well programme and Primary Care Network DES, we have had BCF funded services to support care homes for several years. This includes training, advice and guidance around nutrition, infection prevention and control, medicines management, end of life care, falls management and we are introducing Health Call in all South Tees care homes to support the move to digital care.

Carers Support:
We recognise the pivotal role that unpaid carers play in helping alleviate long term care pressures on the social care and health markets. We will maintain and develop support for Carers to sustain resilience and ensure we prevent carer breakdown, resulting in admission to long term health and care settings.

From a top-down approach we will also help to ensure new carers taking on a caring role for the first time are supported to maintain the role while at the same time ensuring carers are able to live active fulfilled lives for themselves. We will do this by adopting pro-active, preventative services and systems.

Both Redcar & Cleveland Borough Council and Middlesbrough Council are committed to developing joint carer support services for unpaid carers, and from April 2022 onwards will have commissioned the South Tees Carers Support Service. The service encompasses not only hospital-based support but primary care and pharmacy liaison services, mental health support and core adult and young carer support in the community. Most of these services will be commissioned utilising BCF resources and will be focused on identifying carers at the earliest opportunity to ensure they are supported adequately to maintain the caring role where it is the carers wish to do so. Community providers will deliver case management for each carer and will offer vital links to the local authority for statutory Carer Assessments and Parent Carer Needs Assessments. There will be an emphasis on collaborative approaches with multiple service providers delivering the South Tees Carer Support Service.

Key Changes:
In summary the key changes to our previous BCF plan are new schemes to support quicker effective discharges and maintain independence. Examples include the Home First service, Frailty Co-ordinator Team and expansion to reablement and overnight care services.

Governance

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

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

Tees Valley CCG BCF Goverance Overview.p

In South Tees, Middlesbrough and Redcar & Cleveland Council meet together with CCG colleagues in our BCF Implementation and Monitoring Group (IMG). This group is formed of commissioning and finance leads from the 3 organisations and the South Tees Integration Programme Manager and Co-ordinator, who are both jointly funded posts. The BCF IMG meets monthly to collectively plan, review new business cases, monitor performance of schemes and expenditure of Better Care Funds.

The South Tees Executive Governance Board receives recommendations from the BCF IMG about new schemes and expenditure, maintains a strategic overview and makes the decision on how funding should be spent.

BCF plans are considered and approved by the South Tees Health and Wellbeing Executive who will make recommendations to the Joint Live Well South Tees Board (Health and Wellbeing Board for Middlesbrough and Redcar & Cleveland).

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Our South Tees vision for integration is to continue to work together to promote health and wellbeing, reducing dependency and minimising the needs for ongoing care, ensuring our citizens are well informed and can access the right services at the right time in the right place. This is achieved through maximising integration opportunities, great partnership working and a real focus on prevention and sustainable outcomes.

To achieve our vision we need to successfully meet the demands and challenges being placed on the system as a result of demographic and socio-economic changes, in particular the impacts of covid-19, an ageing population, significant health and social deprivation across our region and reducing workforce resources. Providers and commissioners across health and social care are working together to further develop the common purpose, trust and level of shared accountability required to respond to the challenges faced.

Joint and collaborative commissioning will be progressed through the emerging ICP development. To support this we have set up the South Tees Executive Governance Board (STEGB) which has Director level membership from Middlesbrough and Redcar & Cleveland Social Care, the CCG, Public Health, South Tees Hospitals NHS Foundation Trust and Tees Esk and Wear Valleys NHS Foundation Trust.

The purpose of the STEGB is to provide direction and oversight regarding system wide working at place and to ensure a population health approach across the place based health and care economy, which in turn will ensure sustainable high quality services and outcomes against local and wider system plans. It provides strategic and operational leadership and oversight for South Tees activities, building on national direction, and local plans, but emphasising the partnership approach and an agreed strategy for sustainability and transformation built up from local and system plans. This offers the opportunity for joint commissioning through the BCF programme.

Our Better Care Fund, through joint working, sets a local approach to develop schemes which support prevention and independence. Our Single Point of Access (SPA) model has brought together an integrated co-located team of professionals from each of our partner organisations to create one single point where professionals needing to access health and/or social care services can go without having to navigate their way through the existing maze of access points that can be very difficult to navigate. This will support effective discharge from hospital, help prevent unnecessary hospital admissions and maintain an individual's independence for as long as possible.

We are looking at existing positive examples of integrated personalised commissioning, which are working, and considering the approach other partners have taken to further expand our joint working to deliver more person centred care.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

The various hospital discharge policies which commenced in March 2020 in response to the COVID-19 pandemic provided an opportunity to develop a more standardised and consistent approach to discharge across the ICP.

There has been a shift from previous processes which included limited surveillance of all hospital discharges, a focus on the notification process (which brought multi agency discussions much later in the process) and the previous formal reporting that focussed on DTOCs which challenged integration by way of the data reporting definitions.

The shift to a 'Home First' approach means that discharge planning starts on admission with 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 the same day or the following day.

The ICP has established surge meetings which are flexed (stood up/down) based on pressures and need. Meetings have been closely linked with place based discharge groups to ensure patients were 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 an extended length of stay in an acute hospital bed

There has been a focus in our South Tees locality on discharges since our DToC Peer Review in September 2019. We have been working to implement the national discharge policy and have regular meetings with stakeholders to continually review issues and outcomes.

Our local approach to improving outcomes for people being discharged form hospital and reducing lengths of stay is summarised below:

Home First Strategy

- Development of our system Home First Strategy (embedded above)
- Creation of our Home First Programme Board. This is a system meeting with responsibility for delivery, assurance, oversight and co-ordination of the Home First Strategy and associated improvement plan and projects.
- Weekly Home First Operational Group meetings set up to highlight issues, and work on plans and projects
- Middlesbrough Director of Social Care and Health Integration identified as the SIRO for Home First
- Internal plans and initiatives within South Tees Trust to reduce lengths of stay and expedite the discharge process. They are being supported by ECIST to implement new ways of working and processes.
- Development of a system dashboard to help monitor performance around discharges and discharge to assess and identify pressure points

Through the above we have developed some new services and ways of working, some of which are funded from the BCF and others from the Hospital Discharge Fund available this year. These include:

- Home First Service – planned to be in place from mid-November. This will be delivered by recruiting flexible care staff who will be able to deliver the initial care, reablement or rehabilitation. Working as part of the existing community services, they will provide a bridging service from acute care to community and social care. A blurring of roles (care/reablement) will enable a service to flex around the needs of the person ensuring truly person centred care.
- Transfer of Care Hub model just approved to include a strategic system manager and a dedicated team of Transfer of Care Co-ordinators from both health and social care
- Extension of an existing frailty co-ordination team in the hospital to cover ED
- Expanded hospital social work team and reablement team in the community
- Trusted Assessors working in the hospital who support with discharges to care homes and reablement units

In order to ensure efficient hospital discharge processes we acknowledge that unpaid carers of hospital patients should be recognised and fully involved in the discharge planning process.

We continue to commission hospital-based carer support services from Better Care Fund providing bespoke support in designated hospitals across South Tees. The aim of these services is to identify carers swiftly in the hospital setting, prior to discharge of the cared for person, and provide support planning and triage to additional services and support to equip carers with the tools to embark on the caring role in the community. This will in turn help reduce carer breakdown and the potential for the cared for person to escalate into long term health or care services.

The service will provide dedicated carer support workers across James Cook Hospital and Primary Care Hospitals in the South Tees region who will deliver case management for the carer and also link with health services based within the hospital and community provision to ensure Carers access the services they need, when they need them.

Workforce Pressures:

Our plans have been impacted by the national and local recruitment issues particularly around domestic and social carers. In some instances, despite having funding sources available, including the incentives linked to the Workforce Development Fund, we have not been able to attract and retain staff. This has put pressure on securing prompt packages of care to support with discharges and reducing admissions to hospital.

We continue to work collectively and innovatively as a system to overcome capacity issues. An example of this is the recent successful appointments to our new Home First team outlined above, which potentially attracted staff as they will be employed by the Trust with NHS terms and conditions and the chance for career progression.

Plans from April 2022:

Given the national Hospital Discharge Policy and associated funding ends on 31st March 2022 partners across the Tees Valley are currently evaluating the current discharge pathways, financial information and patient outcomes. We will be considering the additional bed based provision and schemes to support people to return home commissioned as part of the Hospital Discharge policies to assess the impact on patient/ carer outcomes. The evaluation will inform future commissioning intentions/ local plans from 1st April 2022.

We have reserved a risk share allocation in our BCF plans to manage the risk of no further national funding to support discharge to assess costs from 1st April 2022.

Disabled Facilities Grant (DFG) and wider services

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

Middlesbrough Council, as the Housing Authority, developed a number of policies in line with the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to assist residents of Middlesbrough who are disabled or who have a long term health condition to live independently and to carry out essential day-to-day activities. Specifically, it sets out the principles that will be applied in relation to the provision of adaptations, equipment and repairs to prevent the need for Social Care, hospital intervention and to enable a person to continue living independently, comfortably and safely in their own home.
To meet our statutory duty, our priority is to ensure that sufficient funding is allocated to our Disabled Facilities Grants programme however, we have had the flexibility to introduce services which are more reflective to support delayed transfers of care and readmissions to hospital. These include:

1. Small Measures Grant: a grant which is awarded to prevent the need for Social Care and/or hospital intervention or to fast track adaptations when required to enable people to live independently in their own home. An example would include an individual who has no heating which could have a detrimental effect on their health.
2. Disabled Persons Rehousing Assistance Scheme (DPRAS): The purpose of this policy is to assist homeowners to buy a more suitable replacement property where a member of the household has been assessed as requiring major adaptations to the current home.
3. Dementia Grant: This policy is to help residents of Middlesbrough who have dementia to live independently and to carry out essential day-to-day activities. The support in this policy is to be used in conjunction with other preventive services, such as Assistive Technology, Handy Person Services and Major Adaptations to enable a person to continue living independently, comfortably and safely in their own home.
4. Hospital to Home : Our Hospital to Home service continues to focus on the reduction of hospital admissions, re-admissions and to support with timely discharge. We have recently incorporated a 6-week free assistive technology trial

for anybody being discharged. This reduces the risk of hospital re-admission and the amount of domestic care patients may require. A review is undertaken after the 6-week period for longer-term support considerations. We operate as a central hub for all VCS services; providing support for individuals to access mainstream community activities and any additional help that they might need.

Within the local authority we have a lead officer who works across both BCF and DFG ensuring collaboration between both. We have representation from the VCS sector on our HWBB and also our VCS provider is one of the lead organisations in relation to the Carer Strategic Partnership.

Equality and health inequalities.

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

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

The local authority and CCG are committed to making sure equality and diversity is a priority. To do so we aim to work closely with our communities to understand their needs and how best to commission the most appropriate services to meet those needs, we do this by removing or minimising disadvantages suffered by people due to their protected characteristics; taking steps to meet the needs of people from protected groups where these are different and we encourage people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

There is a local approach to person centred care working together in order to make best use of existing expertise, capacity and potential of people, families and communities. We are working across four main groups of people, who typically have high levels of need, across health and social care:

•Children and young people with complex needs, including those eligible for education, health and care (EHC) plans

• Older people with frailty and or/with multiple long-term conditions

•People with learning disabilities with high support needs, including those who are in institutional settings or at risk of being placed in these settings

•People with significant mental health needs, or those who use high levels of unplanned care.

We will work 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.

The embedded presentation was presented to our Live Well South Tees Board at the last meeting, and we will be considering how to progress this across our system.

LWST HIA.pptx

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Better Care Fund 2021-22 Template

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Health and Wellbeing Board:	Middlesbrough
Completed by:	Kathryn Warnock
E-mail:	kathryn.warnock@nhs.net
Contact number:	07766554805

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

Job Title:	Director of Adult Social Care and Health Integration
Name:	Erik Scollay

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 09/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Andy	Preston	andy_preston@middlesbrough.gov.uk
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	Local Authority Chief Executive		Tony	Parkinson	tony_parkinson@middlesbrough.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Erik	Scollay	erik_scollay@middlesbrough.gov.uk
	Better Care Fund Lead Official		Suzanne	Hodge	suzanne_hodge@middlesbrough.gov.uk
	LA Section 151 Officer		Ian	Wright	ian_wright@middlesbrough.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					@
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5a. Expenditure	Yes
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Health and Wellbeing Board:	Redcar and Cleveland
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Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Patrick Rice
Name:	Corporate Director Adults and Communities

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 09/12/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
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	Better Care Fund Lead Official		Victoria	Wilson	victoria.wilson@redcar-cleveland.gov.uk
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5a. Expenditure	Yes
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7. Planning Requirements	Yes

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LiveWell SOUTH TEES

South Tees Health and Well-being Executive Assurance Report

To:	Live Well South Tees Health and Wellbeing Board	**Date:**	December 2021
From:	Dr Ali Tahmassebi – Chair South Tees Health and Wellbeing Executive	**Agenda:**	Item 8
Purpose of the Item	To provide South Tees Health and Wellbeing Board with assurance that the Board is fulfilling its statutory obligations, and a summary of progress in implementing the Board's Vision and Priorities.		
Summary of Recommendations	That Live Well South Tees Health and Wellbeing Board: • Are assured that the Board is fulfilling its statutory obligations • Note the progress made in implementing the Board's Vision and Priorities		

1 PURPOSE OF THE REPORT

1.1. To provide South Tees Health and Wellbeing Board (HWB) with updates on progress with the delivery of the Board's Vision and Priorities and assurance that the Board is fulfilling its statutory obligations.

2 BACKGROUND

2.1 To support the Board in the delivery of its priorities a South Tees Health and Wellbeing Executive has been established. The South Tees Health and Wellbeing Executive oversees and ensures the progress and implementation of the Board's work programme and creates opportunities for the single Health and Wellbeing Board to focus on the priorities.

3 PROGRESSING STATUTORY HEALTH AND WELLBEING BOARD FUNCTIONS

3.1 The next section of this report sets out progress the Health and Wellbeing Executive has made against the Board's statutory functions.

3.2 ***Better Care Fund (BCF) 2021/22***

The Better Care Fund update is a substantive item on the December Board meeting.

3.3 **Pharmaceutical Needs Assessment**

The Public Health South Tees PNA process began in August 2021. However, there have been a number of key personnel changes in the autumn of 2021 resulting in some disruption to the project's momentum. A project plan is now in development and implementation will be led via the PNA Steering Group. The first meeting of the PNA steering group will take place in January 2022 and the group will conducts five key meetings to assure the governance of the PNA:

- Meeting 1: January 2022 – agree terms of reference, timelines, project plan, document structure and content.
- Meeting 2: March 2022 – workshop to review synthesised information in draft report, analyse need and outline requirements for section 10 and 11 of PNA.
- Meeting 3: April 2022 – read and approve pre-consultation PNA draft.
- Meeting 4: July 2022 – review consultation report and recommend revisions to PNA.
- Meeting 5: August 2022 – approve final revised PNA and submit to local authorities' for sign-off prior to publication.

A PNA Task and Finish Group will also be established in January 2022 to carry out the day to day work in producing the PNA.

3.4 **Health Protection Assurance Report**

The fourth Annual Live Well South Tees Health Protection Assurance Workshop took place on Friday 19th November 2021 via Teams. The event was attended by 54 delegates from voluntary sector, local authority, NHS, CCG, and education.

The key objectives for the workshop were to develop community wide health protection resilience, ensuring stakeholders understand local health protection arrangements across South Tees, to identify key challenges in contributing to local health protection resilience as well as identifying key community assets that assist in building system wide health protection resilience.

The agenda included an update on emerging health issues from Dr Simon Howard followed by a detailed local authority perspective on health protection from Mark Adams. Public Protection colleagues outlined how the pandemic has affected regulatory services and how their remit changed in response. Dr Mark Fishpool gave a comprehensive overview of the climate crisis and health protection: using a whole system approach, the final speaker Fergus Neilson illustrated how the pandemic has impacted section 7a issues (screening and immunisations) and how these services are recovering after unprecedented pauses in service delivery.

Feedback from the event was highly positive with 83% of participants rating the workshop as 'very good'. Participants found all presentations interesting, informative and useful to varying degrees depending on their own particular area of interest. Several participants expressed they miss the face to face interaction of a physical conference and that virtual presentations can sometimes feel a little rushed.

Recommendations from the workshop include:

1) Structuring the Health Protection Programme to include a) environmental issues and emergency response, b) communicable / infectious disease and outbreak management, c) community resilience and business continuity plans, d) immunisations (childhood, young people, adults and pregnant women), e) screening.

2) Determine the governance and accountability structures for the Health Protection Programme
3) Develop a South Tees Health Protection action plan that includes actions for wider council departments, Education, workplaces, voluntary sector, primary care and care home partners.
4) Hold a South Tees Annual Health Protection Assurance Workshop based on the action plan
5) Produce the Annual Director of Public Health's Health Protection Assurance Report.

4	PROGRESS AGAINST SOUTH TEES HEALTH AND WELLBEING BOARD PRIORITIES

4.1 The Board's agreed vision and priorities are to:

Empower the citizens of South Tees to live longer and healthier lives. With a focus on the following areas key themes:

a. Inequalities - Addressing the underlying causes of inequalities across the local communities;
b. Integration and Collaboration - across planning, commissioning and service delivery; and
c. Information and Data – data sharing, shared evidence, community information, and information given to people.

4.2 Set out below is a summary of the progress the Executive has made towards achieving the Board's priorities since the last Board meeting in September 2021.

4.2.1 **Whole System Change for Best Start in Life**

Heath inequalities for many children and young people across South of Tees begin from pre-conception and follow them throughout their life course. In South of Tees there are approximately 3,700 births per year. The health of many of these children is compromised at birth and unless the gap between local and national experience can be reduced, child health locally will continue to lag behind the rest of the country.

It is now vital that we invest in the under 2 agenda to support the recovery from covid and reduce on-going inequalities faced by Middlesbrough and Redcar & Cleveland residents. The 1001 days project will lead forward a series of local action to impact on the first 1001 days. The project will establish the development of a Best Start Partnership across South Tees which will lead forward local transformation and reframing of service and behaviour change across the population creating sustainability through developing a new way of working.

Project Objectives

The development of a 1001 days Best Start Partnership will strategically lead forward and embed National recommendations from the 1001 days review findings. This will be done through:

- The creation of a 1001 days Best Start Partnership – The partnership will have a critical role in developing and driving forward the 1001 days vision. The Best Start

Partnership will work with national and international experts, build on and utilise local information sources and review evidence base to identify how local expertise can be built upon and enhanced. The hub will work with key strategic leaders to develop a joint vision for the Best Start in Life and oversee that this is implemented in practice. The Partnership will champion change at all levels to ensure a new joined up way of working to ensure that local systems impact on the outcomes for some of our most vulnerable children and families. The Partnership aims to build local expertise and capacity and ensure that evaluation and research is an essential part of the local delivery.

- Reframing and System Transformation – A shared governance board will be established to lead forward the local vision and develop a pathway for turning evidence into local practice.
- Workforce development – We will work with key partners to introduce a shared language for the community and professionals to talk about early child development and create an awareness of how critical early experiences are and the importance of early brain development. The workforce training will ensure all of the early year's workforce and key partners (such as housing and GP's) are able to communicate with families using the common narrative.
- Community engagement – Learning from our local communities and having them co-produce our local vision and delivery is key to reducing inequalities. We will work with our local communities to identify pressures impacting on their ability to provide the Best Start in Life and we will work with these communities to identify ways of reducing any barriers.

<u>Progress to date</u>

- We have established a 1001 days project board which will oversee the project and the key priorities of the Best Start Partnership– board member ship will grow to reflect all key partners
- We have established a Best Start Partnership Board and the following sub groups:
  - 1001 days
  - Improved planning and preparation for pregnancy
  - Supporting families with infant feeding
  - Supporting parents and children to have good mental health
  - Supporting new parents and their children to be of healthy weight
  - Reducing the risks to children and families from smoking
  - Preventing child injury and supporting parents to self-manage minor illness
  - We launched the new Best Start Partnership with a Best start Practice week in November, over 200 attendees from across Local Authorities directorates and key partner agencies came to the events
  - We have initiated the Lock Down Babies research study in partnership with Teesside University

<u>Next Steps</u>

To grasp the support from the Health & Wellbeing Board and key partners to support the delivery of the following milestones within key timeframes;

	Milestone Description	Start Date (Baseline)	End Date (Achieved)
MS1	Agree project scope and approach with Children's Services	July 21	Achieved
MS2	Establish Project Board and working groups	July 21	Achieved
MS3	Develop a project delivery plan via the Best Start Partnership	Sept 21	Jan 22
MS4	Develop a shared outcomes scorecard for monitoring progress	Nov 21	Jan 22
MS5	Develop a shared outcomes scorecard for monitoring progress	Nov 21	Jan 22
MS6	Map current delivery against the 1001 days review and duchess of Cambridge report and produce a recommended transformational route map to meet the recommendations	Sept 21	Feb 22
MS7	Develop an approach to community engagement for the first 1001 days	Dec 21	March 22
MS8	Develop the shared narrative	Feb 22	June 22
MS9	Establish a workforce development programme and identify key workforces for training	Feb 22	June 22
MS10	Develop a 1001 days marketing and communication strategy	Sept 21	On going
MS11	Conduct a needs assessment for 1001 days	Jan 21	May 22
MS12	Conduct community engagement	Feb 21	June 22

4.2.2 Healthwatch Update (from 30 September)

Since the last update provided Healthwatch South Tees (HWST) have been involved in many varied activities. Here's a summary of some examples of this:

TEWV Community Transformation Programme consultation report
Healthwatch South Tees (HWST), the operating name for both Healthwatch Middlesbrough and Healthwatch Redcar and Cleveland, worked in partnership with the Tees Valley Healthwatch Network to create a survey to ascertain local views of accessing mental health and well-being services. We wanted to gain a deeper understanding of what

people's experiences have been- including what has worked well and what hasn't, to identify what potential changes could make a real difference to people.

We received a total of 525 survey responses and spoke to 65 people during the six focus group sessions we facilitated. We made it our priority to connect with seldom heard groups to truly reflect the diversity of South Tees communities. During our focus groups, we spoke to carers, older people, ethnic minority groups and people with a visual impairment. The feedback from our survey highlighted issues with the cross-cutting themes below:

- **Information**
  lack of information publicised about mental health services including who to contact and where to go for support. An understanding of what help is available and how to access support is a priority for people across South Tees.

- **Waiting Times**
  Waiting times for appointments is too long including initial GP appointments and referrals. It is crucial for people get the help and support they need, when they need it.

- **Venue**
  Appointments and support needs to be offered in community venues, drop-in centres and GP surgeries. Having a choice of the venue, somewhere that is easily accessible, on a bus route and not too far to travel is important.

- **Appointment Times**
  Appointments need to be flexible and responsive to individual circumstances such as carer responsibilities, childcare and working hours. A choice of face-to-face appointment, telephone and online video appointments is required.

- **Treatment & groups**
  Feedback from our survey tells us that longer support is needed, changes in support workers do not provide consistency and appointments having to be cancelled can cause additional stress. Groups are not always suitable due to social anxiety and times of the sessions.

- **Reasonable adjustments and Accessible Information Standards**
  As the majority of our consultation targeted our local diverse communities, it has highlighted the importance of this. Too many of our focus group attendees struggled to access support services as they did not know where to go for help or where to find relevant information as it was not produced in a format that met their needs.

The response to our report from Dominic Gardener: Chair of the Tees Valley Mental Health Alliance

We have committed to the below principles moving forward in our redesign:
• There will be no wrong door in accessing help: No referral will be refused.

- We will accept each other’s assessments, so the individual does not have to repeat their story.
- There will be no discharge- patients are able to access services in future if needed without having to be re-referred into services.
- We will work with system partners to ensure care is jointly triaged to ensure the right care in the right place at the right time.

We look forward to continuing our work with Healthwatch throughout the lifetime of this work to provide updates, receive feedback and engage with local voices in shaping the future direction of all mental health services across the Tees Valley.

Adults Safeguarding awareness
We also played a vital role in supporting TSAB with the planning and dissemination of information during Adult Safeguarding Week.

Access to NHS Dental Services
A growing issue for local people is not being able to access NHS dental services. This has also been fed back from other HW Leads across the region, as complaints are increasing. As a result of this, we are working together, across the North East, to identify the scale of the issue locally which we will feed into a regional report. This will then be used to raise awareness and offer recommendations for improvement with North of England Commissioning Support (NECS), the Integrated Care Systems (ICS) and Local Dental Committees (LDC) about this growing concern.

Final reports will be published on our websites as well as shared with relevant stakeholders across South Tees.

GP Access
We continue to gather intelligence about barriers to accessing GP’s. We are focussing on examples of good practice to highlight the impact on a patients experience and outcome when reasonable adjustments have been made. Where adjustments weren’t offered to a patient, we will include suggestions of how this could have been implemented. As we don’t have the power to ensure and monitor that this becomes standard practice, we do aim to highlight the importance of this for the patient.

We have had an agreement in principle, from CQC that they will suggest the inspection rating this would contribute to if the case study was standard practice to all registered patients.

Redcar and Cleveland Scrutiny
We recently received positive feedback to our presentation, highlighting our work over the last 12 months, to those in attendance at the November Redcar and Cleveland Scrutiny Panel meeting.

4.2.3 Integrated Care System Update

On the 11th November, following an extensive recruitment process involving a broad range of health and care partners, the North East and North Cumbria Integrated Care System announced the appointment of Samantha Allen as the new Chief Executive of the Integrated Care Board. Sam will take up the post of Chief Executive of the Board at the end of January, ahead of the Integrated Care System becoming a statutory organisation from April 2022. Sam joins us from Sussex Partnership NHS Foundation Trust where she has been Chief Executive since March 2017. Sam brings a wealth of experience which will be invaluable as we work together to tackle the issues that matter to all of our communities and deliver a shared ambition to reduce longstanding health inequalities, support people to live healthier lives, and deliver the highest standards of care.

Over recent months the Joint Management Executive Group of senior executive officers from the NHS and Local Authorities and chaired by Prof Sir Liam Donaldson, Chair designate of the ICB, met to consider the national guidance on Integrated Care System development, and explore options for the composition of the statutory Integrated Care Board and how we best retain and strengthen integrated placed based working in each of the thirteen local authority areas across the North East and Cumbria. The Joint Management Executive Group has during this time worked to develop recommendations for the Integrated Care Systems governance and operating model for approval by NHS England, who have the final say. This task was supported by the national publication of role profiles for a number of statutory Director roles and required Board members for the Integrated Care Board.

One of the national requirements Integrated Care systems are required to respond to is the development of a draft constitution. This draft constitution must be proposed by the governing bodies of each of the eight existing Clinical Commissioning Groups in the North East and North Cumbria, before it is then submitted in December to NHS England for approval at this stage. Although parts of the constitution are prescribed nationally and not subject to change, the Integrated Care System is seeking views from all health and care partners – and others interested in the work of the Integrated Care Board – on any aspect of the draft constitution. The Integrated Care System is required to submit an advanced draft to NHS England by the 3rd of December, however will keep the document under review prior to formal adoption by the Integrated Care Board when, as expected and subject to legislation, it assumes statutory status from April 2022 onwards.

As a result of the work undertaken by the Joint Management Executive Group, which was informed by a series of virtual multisectoral engagement events that took place over the course of the summer and included membership from the 'Live Well' South Tees Health and Wellbeing Board, the Integrated Care System has now drafted and is sharing more widely, for views and comments, its draft constitution for the new Integrated Care Board.

With the Health and Care Bill now going through Parliament, it is expected that from 1st April 2022 the NHS North East and North Cumbria Integrated Care Board will take over the responsibilities currently held by our eight Clinical Commissioning Groups (CCGs). The Integrated Care Board's role will encompass a wide range of functions including promoting

greater synergy and integration of health and care services, improving people's health and wellbeing and reducing health inequalities.

The ICB will also allocate and maintain good stewardship of approximately £6 billion of NHS funding for the North East and North Cumbria. It will ensure that high quality, safe health services are accessible to all our communities. It will foster, facilitate, and sustain partnerships of hospitals, community service providers, primary care, local councils, hospices, voluntary community, and social enterprise (VCSE) organisations and Healthwatch partners in all thirteen of our local authority areas: Middlesbrough, Redcar and Cleveland, County Durham, Darlington, Gateshead, Hartlepool, Newcastle upon Tyne, North Cumbria, North Tyneside, Northumberland, South Tyneside, Stockton-on-Tees, and Sunderland.

5 RECOMMENDATIONS

5.1 That Live Well South Tees Health and Wellbeing Board:

- Are assured that the Board is fulfilling its statutory obligations
- Note the progress made in implementing the Board's Vision and Priorities

6 BACKGROUND PAPERS

6.1 No background papers other than published works were used in writing this report.

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