Live Well South Tees Board

Thursday 16th January, 2025

Please note that this meeting will be held at The Board Room, North East and North Cumbria Integrated Care Board, First Floor, 14 Trinity Mews, North Ormesby Health Village, Middlesbrough, TS3 6AL.

at 2.00 pm on
Thursday 16th January, 2025

	Agenda Item	Time
1.	**Welcome and introductions** *Alec Brown, Leader Redcar and Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	2pm
2.	**Apologies for Absence** *Alec Brown, Leader of Redcar & Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	
3.	**Declarations of Interest** *Alec Brown, Leader of Redcar & Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	
4.	**Minutes- Live Well South Tees Board - 12 September 2024** (Pages 3 - 6) *Alec Brown, Leader of Redcar & Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	
5.	**South Tees Health and Wellbeing Strategy: Mission Led Approach - Discussion Paper** (Pages 7 - 16) *Mark Adams, Director of Public Health South Tees*	2.15pm

6.	**Health Protection Assurance Report** (Pages 17 - 52) *Sarah Slater, Advanced Public Health Practitioner, Public Health South Tees*	3.15pm
7.	**Health and Wellbeing Executive Assurance Report** (Pages 53 - 94) *Kathryn Warnock, South Tees Integration Programme Manager*	3.45pm

Date and time of next meeting

Thursday 27th March 2025 – 2pm

LIVE WELL SOUTH TEES BOARD

A meeting of the Live Well South Tees Board was held on Thursday 12 September 2024.

PRESENT: M Adams, D Gardner, J Sampson, A Tahmassebi, L Bosomworth, M Davis, K Warnock, C Cooke - Elected Mayor (Co-Chair), Brown (Co-Chair), Earl, J Ryles, Brown, Robson, Short, Swainston and Tovey

OFFICERS: J McNally

APOLOGIES FOR ABSENCE: P Neal, C Heaphy, D Gallagher, B Kilmurray, P Rice, M Graham, R Scott, R Harrison, P Storey, Joynes, Z Uddin, P Gavigan, Suthers, J Tynan, Rawson and J Lavan

24/1 **WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting and introductions were made.

24/2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received at this point in the meeting.

24/3 **MINUTES- LIVE WELL SOUTH TEES BOARD - 18 JANUARY 2024**

The minutes of the Live Well South Tees Board meeting held on 18 January 2024 were submitted and approved as a correct record.

24/4 **SOUTH TEES HEALTH AND WELLBEING STRATEGY**

The Director of Public Health South Tees presented the draft South Tees Health and Wellbeing Strategy to the Board.

Members were reminded that the South Tees Health and Wellbeing Board had a statutory duty to produce for their population: a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. The Health and Wellbeing Strategy outlined the Health and Wellbeing Boards aims to improve the health and wellbeing of people in South Tees and reduce health inequalities.

Members were advised that the Strategy aims to:

- Tackle complicated problems which cannot be solved by any single agency.
- Commit a wide range of partners to working together to explore local issues and challenges, agree priorities to respond collaboratively, using collective resources.
- Be informed by the JSNA that uses data, intelligence and evidence to identify the current and future health and social care needs of the population in South Tees.

The vision of the Health and Wellbeing Strategy was to empower the citizens of South Tees to live longer and healthier lives. The strategy was broken down into 3 aims, Start Well, Live Well and Age Well.

Start Well – Children and young people have the best start in life, we want children and young people to grow up in a community that promotes safety, aspiration, resilience and healthy lifestyles.

Live Well – People live healthier and longer lives, we want to improve the quality of life by providing opportunities and support so more people can choose and sustain a healthier lifestyle.

Age Well – More people lead safe and independent lives, we want more people leading independent lives through integrated and sustainable support.

Members heard that there would be a mission led approach to the principles behind the selection of the Live Well missions.

- Important and improving it will contribute to the citizens of South Tees living longer and healthier lives;
- Broad enough to include many areas that would need to feed in to shift the outcome(s);
- Tackles complicated problems which cannot be solved by any single agency;
- Long term solution of many parts required;
- Understandable, particularly by partners;

Each Mission was a response to a significant local challenge, one where innovation, working together and aligning resources had a big part to play in driving large-scale change. Missions cannot be resolved by any single agency acting in isolation.

Start Well

- We will narrow the outcome gap between children growing up in disadvantage and the national average.
- We want to improve education, training and work prospects for young people.
- We will prioritise and improve mental health outcomes for young people.

Live Well

- We will reduce the proportion of our families living in poverty.
- We will create places and systems that promote wellbeing.
- We will support people and communities to build better health.
- We will build an inclusive model of care for people suffering from multiple disadvantage across all partners.

Age Well

- We will promote independence for older people.
- We will ensure everyone has the right to a dignified death.

The Head of Public Health South Tees stated that the draft strategy presented a mission and goal approach to significant challenges across South Tees and had been informed by the development of the Joint Strategic Needs Assessment.

The Live Well South Tees Board were asked to agree the draft Strategy, the process to develop a public facing document and the proposal to deliver the strategy using a mission led approach.

ORDERED: the Live Well South Tees Board agreed to the draft strategy.

24/5 **HEALTH AND WELLBEING EXECUTIVE ASSURANCE REPORT**

The South Tees Integration Programme Manager presented the Health and Wellbeing Executive Assurance report, which provided an update on progress with the delivery of the Board's vision and priorities and assurance that the Board was fulfilling its statutory obligations.

Members were advised that the Better Care Fund (BCF) plans were assured for 2023-25, however the national team required updates for 2024/25 to reflect any changes in expenditure, outline current performance against metrics and review capacity and demand figures.

The BCF 24-25 planning update templates had been circulated to the Board prior to the meeting. The templates were completed jointly by the BCF Implementation and Monitoring Group members and were submitted before the deadline of 10 June 2024 with the approval from the South Tees Health and Wellbeing Executive on behalf of the Live Well South Tees

Board.

Members were asked to note and formally endorse the BCF 24-25 planning update templates for Middlesbrough and Redcar and Cleveland.

ORDERED: the BCF 24-25 planning updates were noted and formally endorsed by the Live Well South Tees Board.

Members were advised that the Terms of Reference (TOR) for the Live Well South Tees Board had been reviewed and updated, the Live Well South Tees Board were asked to consider and endorse the update TOR.

ORDERED: the Live Well South Tees Board endorsed the updated TOR.

The Healthwatch South Tees Update was provided for information only.

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HEALTH & WELLBEING BOARD

Health and Wellbeing Strategy: Mission-led Approach

Discussion Paper

2024 - 2030

January 2025

1. Mission-led Approach

The significant challenges we face today in South Tees are comprehensive, systemic and long-standing. The challenges are often dynamic and unpredictable, with a lack of consensus on meaningful, long-term approaches across or within agencies. Poorly defined problems, lack of consensus and commitment across partners mean that long term, systemic solutions remain elusive.

The way we work is compounded by short-termism of projects (and often their focus on linear, compartmentalised solutions that don't fit the complex nature of challenges), budgets and limited partnership working making it incredibly difficult to act strategically to address systemic challenges across agencies.

All agencies have been focussed on financial survival for more than a decade – a survival that has got increasingly precarious. This has exacerbated the pre-existing short-termism and limited understanding of the impact of decisions beyond the immediate budget area under consideration. This approach squeezes out innovative solutions across the whole system and reduces the appetite for risk whilst simultaneously not recognising the significant financial risks and poor outcomes contained within the status quo.

The Mission approach allows us to progress as a system and set of partners from pursuing incremental innovation and change, working within existing paradigms (and often within individual agencies), to working together across agency boundaries and with communities to challenge and transform the logic and existing paradigms that has led to the current situation of compounded crises and poor outcomes.

Shifting to a mission-led approach will create the space for us to be more intentional in finding connections, creating a shared agenda to build coherence between different assets, capabilities, and relationships across agencies in the delivery of the mission. This then should support agencies and communities to design portfolios of interventions that are coherent with the challenges we need to address by fully leveraging assets, capabilities, and relationships in the direction of the mission.

Missions are measurable, ambitious, and time-bound objectives that have the potential to help enable transformative change. They are declarations of intent to tackle complex societal challenges, by taking a purpose-oriented, solution-driven, and market-shaping approach.

The LiveWell South Tees Health & Wellbeing Board agreed to a "Mission-led" approach for the development of the Health & Wellbeing Strategy and the Joint Strategic Needs Assessment (JSNA), structured across the life course.

Each mission is a response to a significant local challenge, one where innovation, working together and aligning resources has a big part to play in driving large-scale change – missions cannot be resolved by any single agency acting in isolation. Each mission has a set of ambitious goals that further articulate and explain that mission.

2. Key Areas of Difference in the Mission-Led Approach

"This work is not symbolic like 'systems thinking' – it's more field work than head work"[1].

2.1 System Leadership

2.1.1 Defining System Leadership

The original paper to the HWB proposing the Mission-led approach used the Kings Fund model ("Leadership of Whole Systems") to describe System Leadership, and outlined six "guiding messages" for would-be system leaders:

- Go out of your way to make connections
- Adopt an open, enquiring mind set, refusing to be constrained by current horizons
- Embrace uncertainty and be positive about change – adopt an entrepreneurial attitude
- Ensure leadership and decision making are distributed throughout all levels and functions
- Establish a compelling vision which is shared by all partners in the whole system
- Promote the importance of values – invest as much energy into relationships and behaviours as into delivering tasks

Systems leadership must exist within and across organisational, cultural and geographical boundaries; often without direct managerial control of resources. This moves beyond individual disciplines – we will not achieve the population shift required by operating within the boundaries of the individual organisations or departments.

Considering this further we need to move beyond the usual suspects in senior roles within public sector agencies and develop leadership roles more broadly across the system. VCS organisations tend to be issue (mission) based and consequently more naturally and intuitively navigate their way around the system and across organisational boundaries.

2.1.2 Recommendations (expanded from the HWB Strategy)

1. **We will identify System Leaders for each Mission** considering the importance of developing new system leaders and engaging with latent system leaders. We will establish our long-term approach to give confidence that our System Leaders could be part of leading something that has the chance to produce real change across partners.

The table over the page identifies where system leaders will be required for the missions.

[1] John Thackara on "islands of coherence" and their importance in systems change

Lifecourse	Mission	System Lead (tbc)
Start Well: Children & Young People have the Best Start in Life	We will narrow the outcome gap between children growing up in disadvantage and the national average by 2030	
	We want to improve education, training and work prospects for young people	
	We will prioritise and improve mental health and outcomes for young people	
Live Well: People live healthier and longer lives	We will reduce the proportion of our families who are living in poverty	
	We will create places and systems that promote wellbeing	
	We will support people and communities to build better health	
	We will build an inclusive model of care for people suffering from multiple disadvantage across all partners	
Age Well: More people lead safe,	We will promote independence for older people	
	We will ensure everyone has the right to a dignified death	

Discussion

- There is the potential for a system leader to be from one Council. Are we happy that they can lead across South Tees or does this rule out Council staff as System Leaders?
- Do people have nominees for the other Missions (and potentially those with nominated leaders)?
- Who should be part of the "system leader support" from each agency/function?

2. **We will develop a model of support for System Leaders that considers**:

- Supportive methodologies for problem-solving and decision-making (for example connecting into the HDRC "sandpit" approach; development of theory of change) – to build true understanding, moving away from the more nuts and bolts, traditional, linear thinking model;
- Clarity on the role of System Leader, focussing on leadership, insight and learning. Transformational change will be achieved through influence across the system rather than formal power, with partners aligned and committed to the Mission;
- Training and support on building a learning culture; capturing, sharing learning and contributing to the development of the Learning Framework, engagement with other Missions, accountability and reporting cycles. Training is in development through the Agility in Complexity programme built from the learning of the YGT system change programme.
- Recognition of the opportunity to engage with others with valuable skills and experience and attributes to create effective systems leadership.
- Support team drawn from all relevant agencies

Discussion

- Does this make sense? Omissions? Amendments? Issues?

3. **We will create a regular facilitated space for System Leaders to identify and share learning, achievements, barriers, issues and decision-making governance**.

   The Health and Wellbeing Strategy establishes that the nine missions are strategic priorities across the partnership. This establishes the legitimacy of System Leaders (and their support and associated Partnerships) to expect that learning is built into system change more broadly, and to articulate barriers on the expectation that barriers and issues are addressed through the **South Tees Place Partnership** and up to the **Health and Wellbeing Board**.

Discussion

This could be really powerful and challenge structural issues that have prevented progress previously. Barriers are likely to include approaches to commissioning and procurement, employment, strategy development and decision making, pooled budgets – plus other stuff.

- Whatever the learning and barriers, this will be challenging to how we work now – are people ready for this? Do you think this is the right approach?

2.2 Mission-level Governance

Mission-oriented approaches require the ambition to transform landscapes rather than just fixing problems in existing ones. Public sector organisations face barriers to achieving this transformation. Without addressing these in a systematic matter, the potential for mission success is limited.

To deliver our missions we need to consider how we **break silos within and between agencies** and **coordinate action across portfolios and agencies**. Complex organisational structures, with rigid formal processes, limit the flow of information, reduce openness and constrain creativity.

Whilst the Health and Wellbeing Board and the South Tees Place Committee will provide over-arching governance of delivery of this Strategy – **assuring progress, collating learning and removing barriers**, we will develop a new bold and ambitious governance structure at a mission-level, that develops leadership across the system; facilitates cross-agency coordination built on insight and information sharing to build shared understanding; engages communities; encourages calculated risk- taking, experimentation and development of innovative solutions; embraces the learning approach; generates new perspectives and new thinking and connects into existing Partnerships**.**

There are local examples emerging that demonstrate a different, outcome-focussed approach to working, including Thrive at Five and the Increasing Attendance programmes in Redcar & Cleveland the STRiVE Boards and You've Got This, the Sport England Local Delivery Pilot.

2.2.1 Principles

In the first instance the Mission-level governance will seek to progress within existing organisational parameters and financial models. However, the regular facilitated space for System Leaders to identify and share learning, achievements, barriers, issues and decision-making governance may create the need to revisit this where existing organisational cultures and parameters are limiting the ability to deliver the Missions.

The Mission-Level Governance model can be described by the following principles:

1. Develops leadership across the system
   This is described in the System Leadership section above.

2. Embraces the learning approach
   This is described in the Developing our Learning Approach section below.

3. Engages communities
   This is described in the Engaging Communities and People with Lived Experience section below.

4. Facilitates cross-agency coordination built on insight, and information sharing to build shared understanding
   There is a common theme across multiple missions emerging from the JSNA on the importance of improving **information sharing** to build shared understanding – that also highlights the limited sharing of information that happens in our current ways of working.

   We will develop a greater understanding of data collected across the system and explore data sharing agreements to enable the development of shared intelligence to build a more comprehensive understanding of issues and solutions at a Mission level. **This will be a cross-mission workstream.**

   Insight developed from the perspective of communities, service users and others impacted by the specific Mission will naturally cross service and organisational boundaries (as the work to develop the JSNA and the HWB Strategy did). This should provide the platform and rationale for cross-agency co-ordination in pursuit of the Missions.

5. Encourages calculated risk-taking, experimentation and development of innovative solutions
   The Mission-led model has to be prepared to test new approaches that challenge existing assumptions and ways of working. The model also has to accept that some of these approaches may fail, and learn from that failure in designing the next iterations. Calculated risk-taking accepts failure, within simple parameters where nobody is harmed and financial impacts are limited. This approach can be built on insight that demonstrates that existing approaches in some areas for some people can cause harm, so the risk of the "do nothing" option isn't neutral but can cause harm in some circumstances. Note – this is the approach that South Tees FT are developing in their health inequalities work, considering harms created by long waits.

6. Generates new perspectives and new thinking
   Developing the team to support the System Leader is critical and should extend beyond the usual suspects to include academic partners, VCS, communities and others with different and seldom

heard perspectives. In addition the approach to much deeper community engagement and the learning approach should develop insight that in turn generates new perspectives and new thinking.

Building a social value perspective into all of the work of the Missions will create a different lens to consider decision-making for Missions.

7. Connects into existing Partnerships
   The Missions will need to connect into and draw support from existing Partnerships operating in the same or similar fields. It is important this this relationship is based on support, removing barriers, sharing learning and insight rather than the traditional focus on assurance models and RAG-rating.

2.2.2 Recommendations

4. We will develop mission-level governance structures to support the delivery of the missions that consider devolved autonomy to facilitate information sharing, support mission leadership and enable more agile decision-making across agencies.

5. We will connect our mission-led approach to the Tees Valley Anchor Network to explore the additional value we can generate by coordinating missions across approaches to procurement, employment, education and the environment.

Discussion

- Do the principles for Mission-level governance make sense? Is anything missing?

2.3 Engaging Communities and People with Lived Experience

Four cross-cutting principles to guide and under-pin the work of LiveWell South Tees were agreed in December 2017: addressing inequalities, integration and collaboration, use of Information and intelligence, and involvement of residents, patients and service users.

We have embedded the first three principles to varying degrees but haven't systematically embedded in our work as a Partnership the "**involvement of residents**".

There are pockets of engagement within the Partnership, including Health Champions, the HDRC Community Researchers and others, but nothing that systematically informs policy development and decision-making. Engaging communities is a critical element of the mission-level governance and a key vehicle to generate new perspectives and new thinking and development of innovative solutions. Deeper connections into communities will also connect missions to assets that exist in our communities.

The Poverty Sprint work in Middlesbrough has recommended the development of a **Poverty Action Network**, which aims to:

- Build relationships and trust between local people and civic leaders that increase understanding of poverty;
- Prompt changes in policy and practice within organisations;
- Provide a positive example of co-production;
- Develop new skills for all participants which can be applied to other programmes;
- Maximise on the Local Motion investment by putting forward actions using the devolved budget.

The Poverty Action Network is being developed by LocalMotion in Middlesbrough and the support of the Council could create greater impact.

2.3.1 Recommendations

6. We will develop a model of mission-level community engagement that is embedded into policy development, decision-making and learning processes to inform the development of our plans and approaches to deliver the Missions.

Discussion

- The Poverty Action Network is a Middlesbrough-only recommendation at present, although there have been discussions in both Council areas on the development of a Poverty Truth Commission. Is this an approach that could be developed across South Tees to support meaningful engagement for all Missions? Could it be developed further to influence local policy development and decision-making more broadly than both Councils?
- Poverty is a critical issue driving issues across all Missions, however does the focus on poverty create any issues?
- There will be different communities of interest (inclusion health groups, older people for example) that will need to be engaged too – are there any existing mechanisms that we could tap into?

2.4 Developing our Learning Approach

A mission-based approach requires a methodology that seeks to develop, test, learn and scale a set of interventions that are complementary and can shift complex systems by focusing on multiple intervention points at a given time. The missions, goals and portfolio then become a platform for strategic learning and action: to understand the dynamics of the problems we are trying to impact, and over time more accurately understand the aligned interventions.

This will require a shift from a culture focussed on compliance and policing the boundaries to one of learning and continuously adapting; collectively embracing the complexity arising from a portfolio of diverse projects, activities and initiatives designed for long-term transformation together with communities, people with lived experience and strategic actors in the system. It will require a willingness to let go of power and the false sense of security provided by our current ways of working with a narrow focus on operational performance and thin single-agency measures.

We have developed expertise in this area in the work of You've Got This and their whole system approach to supporting the least active to be more active. YGT is developing a capacity-building

package for leaders at all levels of the system that will help to define and outline approaches for how we can apply a "learning approach", developing distributed leadership across the system and approaches to system change. YGT is committed to resourcing this training and support as part of their legacy.

South Tees is also a **Health Determinants Research Collaboration** (HDRC), which puts us in a very strong position to build longer term learning and research into how we work, in particular to draw down research funding to help us to understand better knotty issues in our own context. The HDRC provides a platform for greater collaboration between Middlesbrough and Redcar & Cleveland Councils and Teesside University (and other Universities). There are nominated academic leads for each life course element of the Health and Wellbeing Strategy.

2.4.1 Recommendations

7. We will develop our learning approach and shared understanding of system change building on the learning from YGT to coordinate action across agencies to deliver our Missions.

Discussion

The learning approach is a fundamentally different approach to how we work now. If it's true that we require a shift from a culture focussed on compliance and policing the boundaries to one of learning and continuously adapting and collectively embracing the complexity are we ready to support this approach in the delivery of the Missions? What do we need to do to create the space for this approach? What could the barriers be to developing this approach?

2.5 Delivery through the Policy Frameworks and Powers

To achieve sustainable change across the system we need to develop clear connections into the Policy Frameworks in both Councils and partners to develop real health in all policies and amplify the delivery of the Missions.

In addition we need to **broaden our scope** from commissioning and services to how we can exploit roles and powers of both Councils and partners to support the delivery of our Missions, including:

- General Power of Competence that gives councils the power to do anything an individual can do provided it is not prohibited by other legislation;
- Regulatory - including licencing, cumulative impact policies and potentially including alcohol minimum unit pricing;
- Planning - including affordable homes requirements, local energy planning;
- Convening - including to improve the performance of partners or collective action to reduce energy costs through community energy schemes;
- Asset and landowner– potential to develop community-based solutions using Council or NHS land or buildings;
- Bidding powers to bring in external resources to support delivery of the Missions;
- Finance powers including exploring innovative funding mechanisms.

2.5.1 Recommendations

8. We will work with both Councils and partners to embed the ambitions of the HWB Strategy Missions into organisational policy frameworks.

9. We will consider how we can better use roles and powers of both Councils (and partners) to deliver our Missions.

3. Live Well South Tees Health and Wellbeing Board

The Board are asked to consider and endorse the recommendations outlined above.

Mark Adams
Director of Public Health for Middlesbrough and Redcar & Cleveland
03 January 2025

South Tees Health Protection Assurance Report 2023-24

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Version Control

Date	Amendments	Review Date	By

Contents

1. Introduction

Local Authorities through their Director of Public Health, require assurance that appropriate arrangements are in place to protect the public's health. This report provides a summary of the assurance functions of the Public Health South Tees Health Protection Assurance Partnership and reviews performance for the period of 1st April 2023 to 31st March 2024 for the Live Well South Tees Board.

This report considers the following key domains of Health Protection

- Protection from environmental hazards
- Prevention of communicable diseases and outbreak management
- Improvement of community resilience around health protection issues
- Increase equitable uptake of immunisation programmes
- Increase equitable uptake of screening programmes

The delivery of robust health protection functions relies on effective partnership working between several local, regional, and national agencies. These include Local Authority (Public Health and Public Protection), UK Health Security Agency (UKHSA), North-East and North Cumbria Integrated Commissioning System (ICS), Integrated Care Board (ICB) South, NHS England / Improvement (NHSE/I), South Tees Hospitals NHS Foundation Trust, Cleveland Emergency Planning Unit (CEPU), Local Resilience Forum (LRF) Voluntary and Community Sector organisations. This report reflects the contributions that all partner agencies make towards the health protection agenda.

2. Health Protection Assurance Arrangements

2.1 Organisational roles and responsibilities

UK Health Security Agency through its consultants in health protection lead epidemiological investigations and specialist health protection response to public health outbreak or incidents. They have responsibility for declaring a health protection incident, major or otherwise and are supported by local, regional, and national expertise.

NHS England is responsible for managing and overseeing the NHS response to any health protection incident that threatens the public's health. They are also responsible for ensuring that their contracted providers deliver an appropriate clinical response.

The ICB is responsible, through contractual arrangements with provider organisations, for ensuring that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening, immunisations, diagnostic and treatment services).

Local Authorities through the Directors of Public Health or their designate have overall responsibility for the strategic oversight of an incident or outbreak which has an impact on their population's health. The Live Well South Tees Board should ensure that appropriate response is put in place by NHSE/I and the UKHSA, supported by the South ICB. In addition, they must be assured that the local health protection system response is robust and that risks have been identified, are mitigated against, and adequately controlled.

The Cleveland Emergency Planning Unit (CEPU) provides an emergency planning service to the four local authorities in the former Cleveland area. Their role is to ensure the local authorities are prepared to respond to emergencies and to support the emergency services and the community. Cleveland Local Resilience Forum (LRF) provides a structure to help agencies plan and prepare for major incidents and meet their statutory duties under law (the Civil Contingencies Act 2004

(Contingency Planning) Regulations 2005 and accompanying statutory guidance entitled "Preparing for Emergencies").

The Health Protection Assurance Partnership provides assurance to the Live Well South Tees Board that adequate arrangements are in place for prevention, surveillance, planning and response to communicable diseases and environmental hazards. The Partnership also provides specialist advice and oversight to the health protection team to ensure delivery of the work programme priorities.

3. Protection from environmental hazards

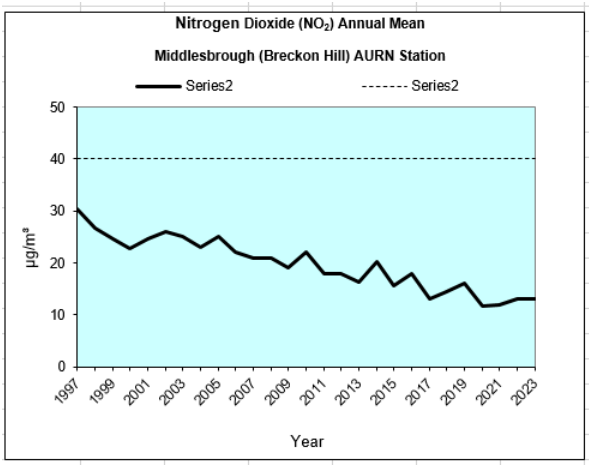
3.1 Organisational roles and responsibilities

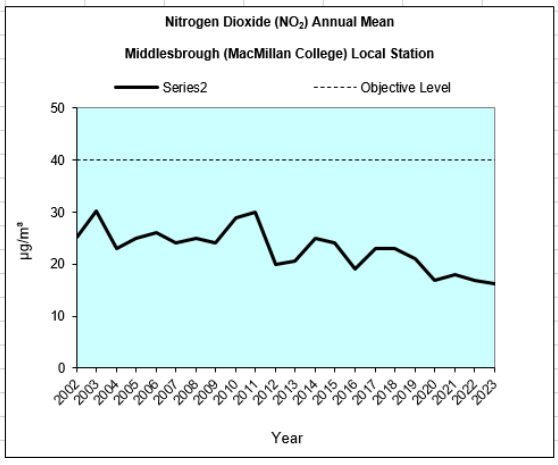
Two local authority services including Middlesbrough's Public Protection Service and Redcar & Cleveland's Health Protection Health Care Quality Service are the regulatory services that respond to issues arising within residential, commercial, workplace and external environment, which may affect health, safety or wellbeing. The Public Protection Service delivers the traditional Environmental Health functions, which contribute to a range of local health protection priorities as described below.

3.2 Air quality (incl. surveillance arrangements)

Middlesbrough produces an annual Air Quality Status report to DEFRA, which details the previous year's air quality monitoring results for the borough and actions taken to reduce pollution. Monitoring results over the years has identified that Middlesbrough's air quality is compliant with national standards and although Middlesbrough is close to the industrial areas of the Tees Valley, the main source of pollution comes from road vehicles. As a result, the council promotes actions to reduce vehicle use and encourages the use of low emission vehicles, walking and cycling. A Clean Air Strategy for the South Tees area was approved and launched in July 2024.

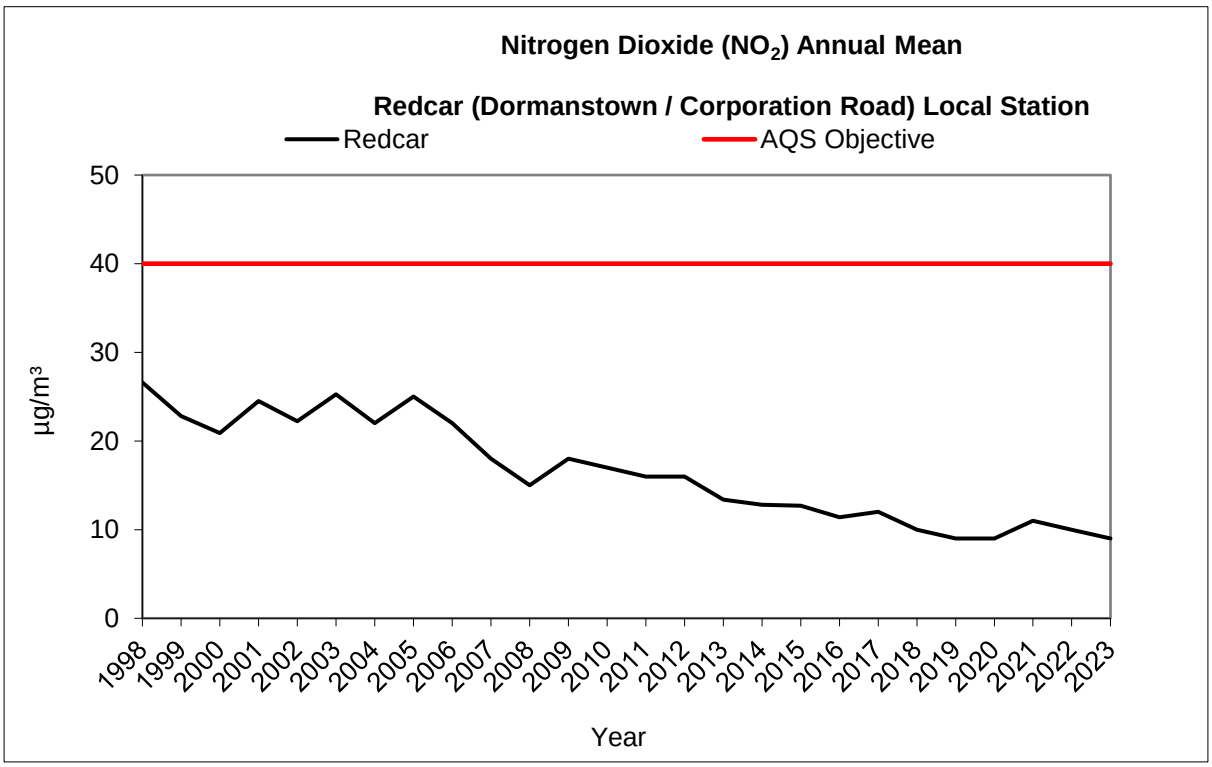
The following graphs, taken from the 2023 Annual Status Report as mentioned above, show the continuing fall of NO_2 levels in Middlesbrough over the last 20 years or so, measured at Breckon Hill Primary School and Macmillan College. Both graphs show the national standard is complied with fully – the annual average level in Middlesbrough being approximately half of what is allowable nationally.





Redcar & Cleveland produces an annual Air Quality Status report to DEFRA, which details the previous year's air quality monitoring results for the borough and actions taken to reduce pollution. Monitoring results over the years has identified that local air quality is compliant with national standards and although Redcar & Cleveland contains major industrial areas in the Tees Valley, the main source of pollution comes from road vehicles. As a result, the Council promotes actions to reduce vehicle use and encourages the use of low emission vehicles, walking and cycling. A joint Clean Air Strategy between Middlesbrough and Redcar & Cleveland Councils was published in March 2024. The strategy compliments the annual Air Quality Status report to Defra and explains how air quality is monitored and how we are trying to improve it. A defined action plan including milestones and performance measures aims to improve and prevent deterioration of air quality across South Tees.

The following graph, taken from the 2024 Annual Status Report as mentioned above, shows the continuing fall of NO_2 levels in Redcar & Cleveland over the last 20 years, measured at Redcar Dormanstown site. The graph shows the national standard is complied with fully – the annual average level in Redcar & Cleveland being approximately one quarter of what is allowable nationally.

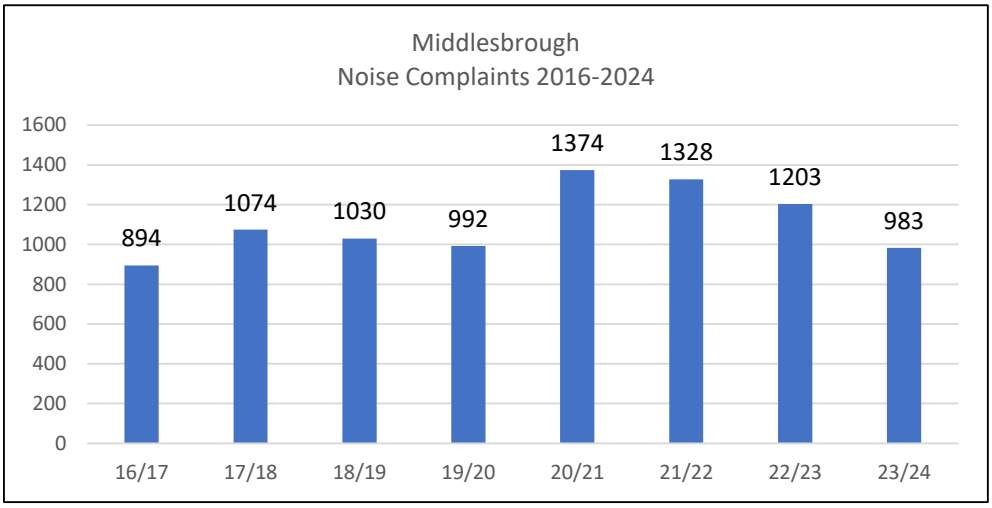


3.3 Environmental Noise

The Public Protection Service responds to complaints about noise, and reviews planning and development applications under licensing laws to ensure the licensing objectives, which include the prevention of public nuisance, are met.

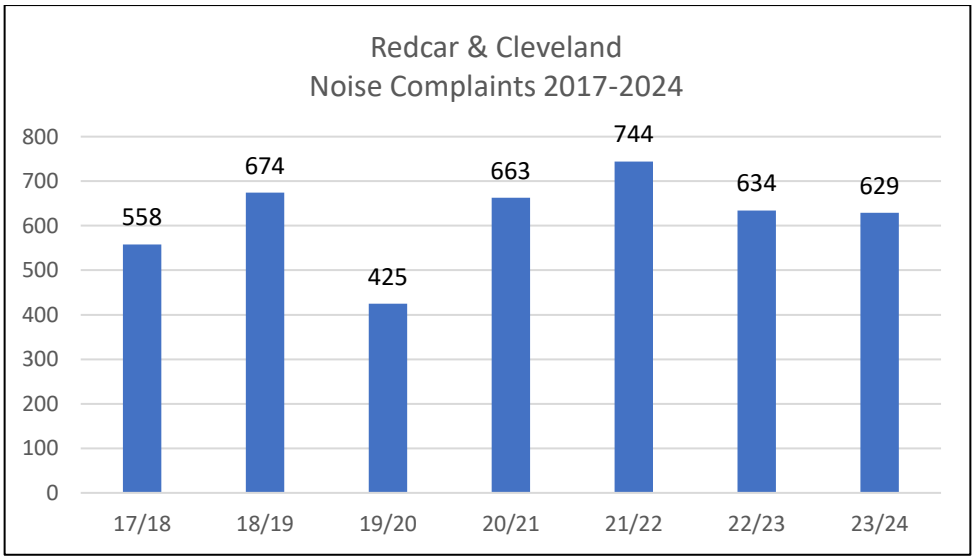
In Middlesbrough the number of noise complaints received for 2022-23 was 1203. In 2023-24 there were 983 noise complaints. Whilst there are a significant number of complaints, most of these are resolved without the need for enforcement action. In 2022-23 only 3 Abatement Notices were served and 4 in 2023-24.

The following graph shows the trend in noise complaints over the past 8 years:



In Redcar & Cleveland the number of noise complaints received for 2022-23 was 634. In 2023-24 there were 629 noise complaints. Whilst there are a significant number of complaints, most of these are resolved without the need for legal action. In 2022-23, no Abatement Notices were served and neither in 2023-24. In 2022-23 1 Community Protection Warning (CPW) was served and 2 Community Protection Notices (CPNs) were served. Whilst during 2023-24, 6 CPWs were served and 4 CPNs, the majority of our complains arise from single family households (427) and are in relation to barking dogs, loud music, and parties.

The following graph shows the trend in noise complaints over the past 6 years. Covid-19 did not have an impact on any category of noise complaints.



3.4 Housing standards

Housing has an important impact on health and well-being: good quality, appropriate housing in places where people want to live has a positive influence on reducing deprivation and health inequalities by facilitating stable/secure family lives. This in turn helps to improve social, environmental, personal and economic well-being.

Conversely, living in housing, which is in poor condition, overcrowded or unsuitable, will adversely affect the health and well-being of individuals and families. People want and need different things from housing throughout their lives - they need to find housing in the right place to enable them to find work, maintain contacts with friends and family and often to provide care.

Housing needs to be suitable for the size and shape of the household, with space for children, or good accessibility in older age. A decent, affordable home is an essential requirement for tackling health inequalities and reducing the burden on health and social care services and cost to the public purse. Housing is a wider determinant of health, and good quality housing which meets the needs of an individual, supplemented by support services where required, can promote independence and well-being.

The private sector housing services at Middlesbrough and Redcar & Cleveland offer comprehensive housing advice to residents and property owners. The Council's use statutory powers to assess housing standards and, if necessary, require landlords and other relevant persons to make improvements to their properties. This includes;

- the licensing of Houses in Multiple Occupation (where there are at least five occupants living as more than one household)
- licensing of private rented properties in designated selective landlord licensing areas
- inspection of properties to determine if 'category 1 or category hazards' exist and to take appropriate action to remedy substandard conditions
- remedy of statutory nuisances linked to housing conditions
- protection of properties / land from pests
- take remedial action where properties are considered to be filthy and verminous
- investigation of allegations of illegal eviction and harassment
- protection of properties that are empty and insecure
- management of empty dwellings – which includes encouraging owners to return their property back into use

Selective Landlord Licensing's role in Improving the Standards in Private Rented Housing.

Certain areas in Middlesbrough have been designated under Selective Landlord Licensing (SLL) and properties in these areas, which includes small HMOs, must have a selective licence if they are let as private rented accommodation. SLL schemes aim to improve standards of accommodation, tackle poor management of properties, reduce anti-social behaviour as part of broader community safety interventions, protect and enhance tenants' rights and support good landlords through tenancy referencing, advice and guidance.

There are currently (August 2024) three Selective Landlord Licensing schemes in Middlesbrough: 'Newport 1 (phase 2), which started in August 2024 and has approximately 1300 properties requiring a licence; 'North Ormesby 2' that started in June 2021 and has approximately 900 properties requiring a licence and 'Newport 2' that started in July 2023 and has approximately 900 properties to be licensed. SLL schemes usually run for five years. The Newport 1 (phase 2) scheme is a redesignation of 'Newport 1' which ended in June 2024.

The Selective Landlord Licensing Team provides a combined health and social approach to ensure that the provision and maintenance of private sector housing meets at least the minimum standard. The most vulnerable, excluded and lowest income sectors of the population often live in private rented accommodation and are often reluctant to complain about poor housing standards. The licence fees generate the income to fund the staffing resource to tackle anti-social behaviour, environmental issues and carry out proactive inspections of the private rented housing to improve conditions.

During the Newport 1 SLL scheme, which ended in June 2024, 183 properties were found to have 'Category 1' hazards. These are defects that have a higher potential to cause harm, such as excess cold, unsafe electrical and gas installations, structural collapse, falls from height and poor fire safety measures. 'Category 2' hazards are defects that a lesser potential to cause harm and include minor structural disrepair, damp and mould in non-habitable areas and other defects that, when risk rated, do not present as significant harm as category 1 hazards. In Newport 1 256 properties had both Category 1 and 2 hazards, and 477 properties had Category 2 hazards only.

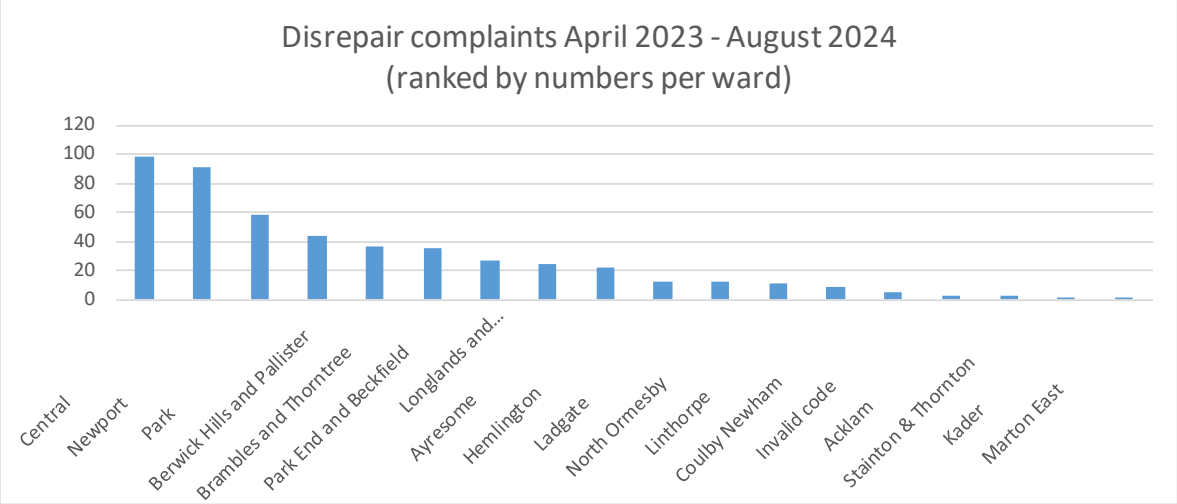
To date (august 2024) Newport 2 has identified 36 properties with Category 1 hazards only, 42 properties with both Category 1 and 2 hazards, and 80 properties with Category 2 hazards only. In the North Ormesby scheme 164 properties have been found with Category 1 hazards, 191 with both Category 1 and 2 hazards, and 106 properties with Category 2 hazards only.

The findings of the housing assessments in the SLL schemes highlights that a significant number of properties do not meet housing standards. The Council will always seek to work with landlords to ensure properties are brought up to standard. However, appropriate enforcement action is taken if landlords / licence holders fail to carry out necessary remedial measures within a reasonable time.

Within Redcar & Cleveland there was one Selective Landlord Licensing (SLL) scheme in operation in the 'Older Street Housing Area of South Bank' which ended in March 2024. This was the second scheme that had operated in the area, running from 2019 to 2024. No significant breaches of the licensing conditions were found during the operation of the scheme and no Category 1 hazards had been identified. Officers continue to undertake a weekly patch walk together with monthly ward member visits to the area. A detailed monthly void walk has been undertaken with all owners of void properties being contacted to try and establish the owner's future plans. A 20% certification compliance check has also be undertaken since the scheme ended on all properties known to be in the private rented sector.

Regulation of Housing Standards in areas outside of the Selective Landlord Licensing Schemes.
For Middlesbrough, in the areas outside of the SLL schemes, the Public Protection Service responds to complaints that tenants make about disrepair in their privately rented accommodation. On average the service receives 380 complaints of housing disrepair a year and in 2023-24 the number of complaints received was 403, plus a further 106 received between April and August 2024.

The following graph shows the breakdown, by ward, of the complaints received about the standards in private rented properties outside of selective licensing areas.



Although the majority of complaints concern disrepair in rented properties, approximately 30% of complaints involve damp and mould. A national focus on damp and mould, particularly in the social housing sector, has raised awareness of substandard living conditions and work has been carried out in Middlesbrough to highlight and investigate damp, mould, and excess cold in private rented properties. This has been combined with work on minimum energy efficiency standards.

The government is proposing changes to housing legislation, including the removal of no-fault evictions, better regulation of social housing and a review of the approach to assessing standards in the private rented sector, with an emphasis on dealing with damp/mould and minimum energy efficiency standards. The new proposals are expected to have an impact on local housing authorities in terms of demand on services, assessment of housing standards, enforcement powers and responsibilities.

Within Redcar & Cleveland the Housing Standards Team responds to complaints that tenants make about disrepair or management within their privately rented accommodation, including report of illegal eviction and harassment and empty properties. In 2020-21 officers responded to 405 complaints, 604 in 2021-22, and 454 in 2022-23 and 547 in 2023-24 (33 of which were in the SLL area of South Bank).

The following graph shows the number of complaints received about the standards in private rented properties outside of the SLL area.

3.5 Houses in Multiple Occupation (HMOs)

HMOs are usually the cheapest form of rented accommodation and are often occupied by the most vulnerable. Licensing of HMOs is required for properties that have 5 or more occupants made up from two or more households who share common facilities. In Middlesbrough (August 2024) there are 240 licensed HMOs. The number of small, non-licensable, HMOs is not fully known as landlords are not required to secure a licence. However, there are expected to be several hundred small HMOs across the South Tees and work is ongoing to identify such HMOs to inform upcoming borough housing strategies.

HMOs are subject to a comprehensive inspection that looks at the structural condition of the property, its services and facilities, fire safety precautions, gas and electrical safety and overall management. Any concerns regarding the standards in HMOs are responded to quickly using regulatory powers which include the requirement for immediate remedial action or prohibition of the use of the property. Enforcement action is proportionate and undertaken as part of a stepped approach which includes issue of informal schedules of work, service of legal notices, issue of civil penalty or where necessary prosecution. Licences are only issued to HMOs once they have demonstrated they meet housing standards.

In Redcar & Cleveland there are currently 32 licensable HMOs operating within the borough, nine of which were issued in 2023-24. Licenses run for 5 years.

Any concerns regarding the standards in HMOs within both boroughs are responded to quickly using regulatory powers which include the requirement for immediate remedial action or prohibition of the use of the property. Enforcement action is proportionate and undertaken as part of a stepped approach which includes issue of informal schedules of work, service of legal notices, issue of civil penalty or where necessary prosecution.

Premises Causing a Nuisance or Impacting the Wider Environment

In addition to responding to complaints in relation to housing disrepair, housing teams respond to complainants regarding properties causing a nuisance such as accumulations of refuse in a garden, dog fouling within the boundary of a property, filthy and verminous premises, or problems with rodents.

In Redcar & Cleveland in 2020-21 officers responded to 286 complaints, 306 in 2021-22, 345 in 2022-23 and 344 in 2023-24. Enforcement action is proportionate and undertaken as part of a stepped approach which includes engagement with property occupiers / landowners, service of legal notices, work in default of non-compliance with a notice or where necessary prosecution.

3.6 Affordable Warmth

The Housing Standards Team in Redcar & Cleveland also operate a dedicated advice service for our residents, 'Warm & Well', delivered primarily through our Energy & Affordable Warmth Officer. The team offer tailored advice and signposting to grants and assistance to improve energy efficiency and reduce fuel poverty for residents across the borough. In Middlesbrough this activity is led by Middlesbrough Environment City, who also co-ordinate the South Tees Affordable Warmth Partnership.

Alongside the other Tees Valley Local Authorities, both local authorities fund the Stay Safe and Warm Partnership with Cleveland fire Brigade. The Scheme helps residents who struggle to afford to heat their homes, particularly during the colder months.

Over recent years Redcar & Cleveland has also contributed to successful consortium bids with other Tees Valley authorities and the TVCA. These have led to over 275 energy measures being installed in over 200 homes across Redcar & Cleveland via the Government's Local Authority Delivery LAD2 and Homes Upgrade Grant (HUG1) schemes.

Redcar & Cleveland have also been successful in a further consortium bid for HUG2 funding. Following some delays, 100 households across Darlington, Hartlepool, Redcar & Cleveland, and Stockton will be improved. Work will take place from Summer 2024 to March 2025.

3.7 Contaminated Land

There are no sites in Middlesbrough legally defined as being Contaminated Land. However, as more brownfield sites are subject to development, there remains a need to continue to review former industrial areas and carry out assessments of land to determine their suitability for development or, if applicable, protection of health, wildlife, and the environment. The Council's Contaminated Land Strategy was reviewed in 2022 and a revised strategy for 2022–2027 published.

There are no sites in Redcar & Cleveland legally defined as being Contaminated Land under Part 2A of the Environmental Protection Act 1990; such sites may only be identified when they are not subject to the planning regime. However, as more brownfield sites are subject to development, there remains a need to continue to review former industrial areas and carry out assessments of land to determine their suitability for development and if applicable, protection of health, wildlife and the environment. The Council's Contaminated Land Strategy was reviewed in 2013 and published.

The Teesworks site is being developed in accordance with conditional planning approval granted under the Town & Country Planning Act 1990 meaning that the developer has a legal duty to develop the site to be suitable for its intended future use. Contamination risk assessments, options appraisals, remedial actions, and verification requirements must be submitted by the developer to the Local Planning Authority for their acceptance. Post development the site must not be capable of being determined as contaminated land within the meaning of Part 2A of the Environmental Protection Act 1990.

3.8 Control of Environmental and Food Borne Infections

In 2023-24, 593 food businesses were inspected in Middlesbrough to determine compliance with food laws, of which 445 premises (75%) received a 5 rating. 20 food premises were subject to enforced closure due to serious hygiene breaches.

The food inspection programme is prioritised to ensure that high risk premises are inspected more frequently. Most of the food businesses inspected are restaurants and takeaways however there are a small number of manufacturers and approved food premises, and these can involve more complex processes.

The number of notifiable infections in 2021-22, 2022-23 and 2023-24 and are shown below:

Notifiable Infections Middlesbrough	**2021-22**	**2022-23**	**2023-24**
Acute Hepatitis	<5	0	0
Bacillus cereus	<5	0	0
Campylobacter	184	138	107
Cryptosporidium	7	8	18
Dysentery	<5	<5	<5
E.Coli - O157	<5	7	<5
E.Coli - not O157	7	<5	<5
Giardia lamblia	7	0	<5
Listeria monocytogenes	<5	0	0
Salmonellas	15	19	19
Yersinia	<5	<5	<5
Total Cases	**228**	**180**	**156**

The Public Protection Service registers and inspects premises and individuals that provide cosmetic treatments in Middlesbrough. Registered premises includes:

- 42 tattooists,
- 54 providers of body and ear piercing,
- 7 providers of electrolysis,
- 30 providers of micropigmentation and microblading, and
- 20 acupuncturists.

Once premises are registered, the Public Protection team visit to ensure that the byelaws in relation to tattooing, acupuncture, body piercing etc are being adhered to. This visit includes checking cleanliness of the premises, correct equipment being used, appropriate waste disposal to ensure that there are controls in place to prevent a risk to public health.

In January 2024 a tattooist, operating from a home address in Middlesbrough, was prosecuted for failing to register his tattoo studio. After this successful prosecution, the tattooist continued to operate unregistered therefore in May 2024 officers from Public Protection applied to the Magistrates Court for a Part 2A order to confiscate all tattooing equipment from his premises and to prohibit him from operating. Another prosecution file is being prepared for these continuing offences.

In 2023-24, some 648 food businesses were inspected in Redcar & Cleveland to determine compliance with food laws, of which 590 premises (91%) received a 5 rating. No food premises were subject to enforced or voluntary closure. The food inspection programme is prioritised to ensure that high risk premises are inspected more frequently. Most of the food businesses inspected are restaurants and takeaways however there are a small number of businesses which undertake more complex food processes.

The number of notifiable infections in 2021-22, 2022-23 and 2023-24 and are shown below:

Notifiable Infections Redcar & Cleveland	**2021-22**	**2022-23**	**2023-24**
Acute Hepatitis	0	<5	0
Campylobacter	175	164	128
Cholera	0	<5	0
Cryptosporidium	7	12	15
E.Coli - O157	<5	10	<5
E.Coli - not O157)	0	<5	<5
Giardia lamblia	10	0	0
Legionnaires Disease	0	0	0
Paratyphoid Fever	0	0	0
Salmonella - other	<5	<5	<5
Salmonella - type not identified	9	22	15
Shigella Sonnei	0	<5	<5
Suspected Food Poisoning	<5	<5	<5
Yersinia	0	<5	<5
Total Cases	**208**	**220**	**169**

The Licensing Team registers and inspects premises and individuals that provide cosmetic treatments. Registered premises includes:

- 23 acupuncturists,
- 55 cosmetic piercing,
- 6 electrolysis,

- 49 semi-permanent skin colouring and
- 78 tattooists.

3.9 Independent Safety Advisory Group

The Middlesbrough Independent Safety Advisory Group (ISAG) is a is a multiagency body comprising representatives of the Council and Emergency Services. It is facilitated and Chaired by the Public Protection Service in Middlesbrough and by Health Protection Healthcare Quality Service Manager in Redcar & Cleveland. Its role is to provide an independent review of the plans for the delivery of events in the town which meet a range of criteria, to assess and provide advice on their public safety arrangements. The ISAG's review is considered by the Director of Public Health, to provide assurance to him in his delegated decision making to approve an event to go ahead. The group reviews events on public land which meet certain risk criteria, during 2023-24 in Redcar & Cleveland 23 events were consulted on, including sporting events such as running, athletics and cycling festivals as well as Christmas and Bonfire night events. During 2023-24, Middlesbrough ISAG group reviewed the plans for 9 events held on council land.

3.10 Emergency Preparedness

2023-24 has seen some significant developments in resilience with the UK both at a local and national level demonstrated through the Government's Resilience Framework, which is based on the 3 pillars of shared awareness of risk, prevention, and whole society resilience. The framework highlights the role of the Cleveland Emergency Planning Unit (CEPU) and Local Resilience Forum (LRF) and significant learning from the response to COVID, Grenfell and the Manchester Arena.

During the period there were a total of 16 incidents within the South Tees area, none of which were declared as "Major Incidents". The majority of these incidents were a mix of fires, flooding and impacted on residential, care homes and industrial settings. Throughout the year a number of multi-agency meetings have been held in relation to waste fires and extreme weather, ensuring that there is a shared understanding or risk across the partners.

Under legislation training and exercising is undertaken both to train individuals and to test response plans, during the 2023-24 financial period there were 20 training events and 17 exercises with attendance from a range of South Tees organisations (RCBC, MBC etc.). There has been a renewed focus on exploring the concept and practical implementation of community or whole society resilience with a wide range of community groups and representatives and a trial of a small grant scheme to encourage grass roots resilience.

3.11 Severe Weather Plans

In line with national changes, the South Tees Heat Health Plan and the South Tees Cold Weather Plan have been merged to create the South Tees Adverse Weather Plan. All weather alerts issued by the MET Office are cascaded via the distribution list to:

a) Council services including adult social care, children's services, HR, communication teams, homelessness team, customer services, community and culture, as well as the gold and silver level officers;
b) Staff in day care centres, residential homes, schools, nurseries, and children's centres via appropriate council teams listed above.
c) Wider system partners including South Tees Hospitals NHS Foundation Trust, the Local Medical Council (LMC), Voluntary Development Agencies, Integrated Care Board South, and the NE Ambulance Service.

3.12 Excess Winter Deaths (latest data)

There were around 20 (13% higher) excess winter deaths in people aged 85+ in Middlesbrough in 2021-22 and zero (1.6%) excess winter deaths in people aged 85+ in Redcar & Cleveland in 2021-22. This compares to a ratio of 11.3% for England. The ratio is the percentage of additional deaths that occurred in winter months compared to the rest of the year. Older people and people who are seriously ill are at particular risk of death in winter. The number of excess winter deaths depends on many factors, including the temperature and the level of disease in the population and how well-equipped people are to cope with the drop in temperature. The majority of excess winter deaths are due to circulatory and respiratory diseases, rather than direct causes such as hypothermia.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Winter mortality index	Aug 2021 - Jul 2022	8.1	7.2	4.2	18.1	5.4	6.7	5.6	8.4	6.8	11.6	3.3	7.7	5.7	8.1
Winter mortality index (age 85 plus)	Aug 2021 - Jul 2022	11.3	13.6	17.1	38.3	18.7	7.4	13.0	15.5	5.2	8.0	1.6	16.3	10.0	16.9

4. Prevention of communicable disease and outbreak management

4.1 Organisational roles and responsibilities

NHS England has responsibility for managing and overseeing the NHS response to an incident or outbreak, ensuring that relevant NHS resources are mobilised and commanding / directing NHS resources as necessary. Additionally, NHS England is responsible for ensuring that their contracted providers will deliver an appropriate clinical response to any incident that threatens the public's health.

UK Health Security Agency (UKHSA), through its consultants in health protection, lead epidemiological investigations and specialist health protection response to public health incidents or outbreaks and has responsibility to declare a health protection incident, major or otherwise.

The Integrated Care Board South (ICB South) role is to ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks (including screening, diagnostic and treatment services).

Local Authorities through the Directors of Public Health or their designate has overall responsibility for the strategic oversight of an incident or outbreak that impacts on their population's health. They ensure that NHS England and UKHSA, supported by the ICB, put appropriate response in place. In addition, they must be assured that the local health protection system is robust enough to respond appropriately in order to protect the local population's health and that risks have been identified, are mitigated against, and adequately controlled.

General Practices can provide support via the Outbreak Control Team which has potential to be provided at scale via a Primary Care Network (PCN). Further information is available in the Community Infection Prevention and Control Policy for General Practice.

Pharmacies have a responsibility to deliver the Healthy Living Pharmacy (HLP) framework which is aimed at achieving consistent provision of a broad range of health promotion interventions through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. All community pharmacies in South Tees now have HLP status and respond to outbreaks or disease accordingly. Pharmacies are required to participate in up to six health campaigns at the request of NHS England based on local needs. This generally involves the display and distribution of leaflets provided by NHS England. In addition, pharmacies are required to undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation.

4.2 Surveillance arrangements

UKHSA are responsible for the surveillance, including receipt and analysis of formal 'notifications of infectious diseases'. All registered medical practitioners must notify UKHSA when they suspect cases of notifiable diseases. Laboratories performing primary diagnostics must notify UKHSA when they confirm the presence of a notifiable organism. UKHSA collects these notifications and analyses them to detect anomalies which may represent an outbreak, such as more cases being reported then would be expected, or multiple cases of the same infection with exposure to the same venue. UKHSA publishes analyses of local and national trends every week. Weekly summary reports are also shared with public health colleagues.

4.3 Covid-19, Flu and RSV 2023-24

As flu data is not captured and reported at a local level, the graph below highlights weekly rates of influenza, Covid-19 and Respiratory Syncytial Virus (RSV) for England in 2023-24 and provides an indication for when peaks would have been experienced locally.

Figure 2. Respiratory DataMart weekly positivity (%) for influenza by year, England [note 1]

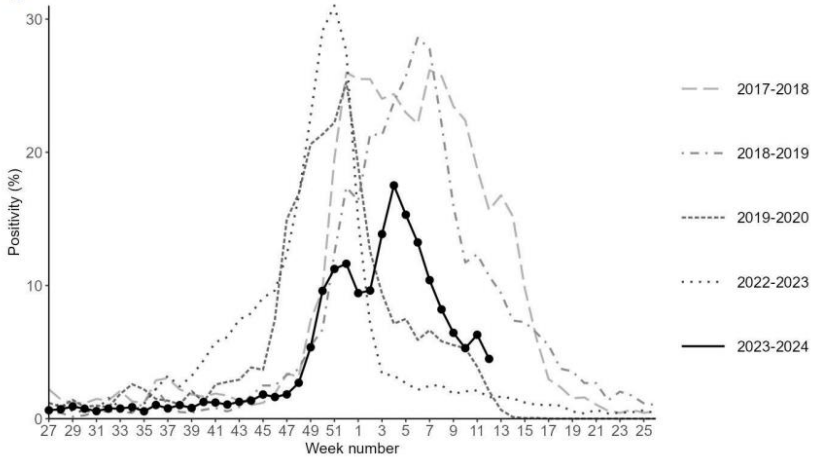


Figure 5. Respiratory DataMart weekly positivity (%) for SARS-CoV-2 by year, England

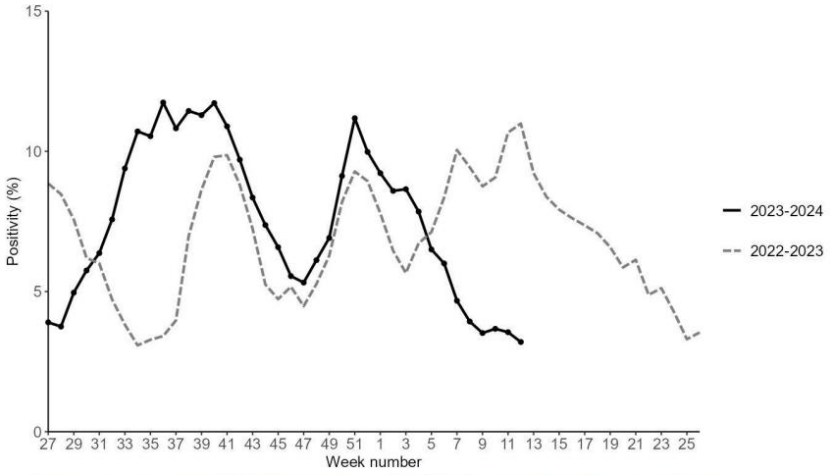
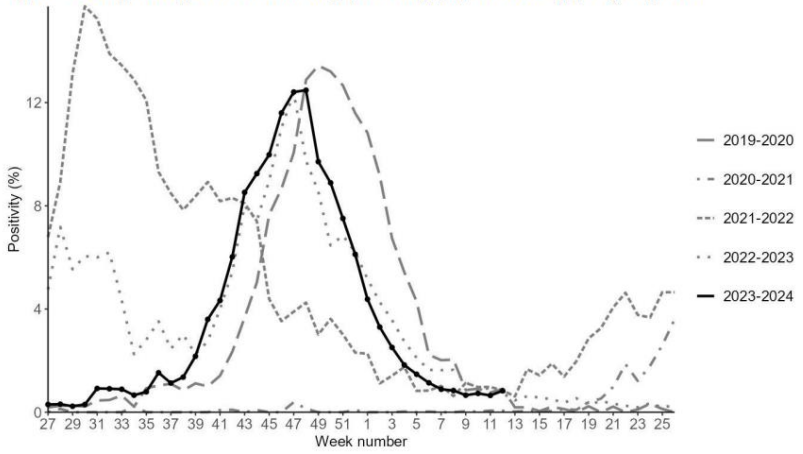


Figure 7. Respiratory DataMart weekly positivity (%) for RSV by year, England



It is important to reduce the number of respiratory diseases as these lead to hospital admissions and put pressure on NHS and social care services.

4.4 Measles

In October 2023 measles cases in the West Midlands began to rise, by 19th January 2024 cases were continuing to rise so a national incident was declared. On 9th February 2024 Public Health South Tees sent a measles warning letter to parents via all schools across South Tees, encouraging parents to check MMR status and ensure that their child was fully vaccinated. The first measles case in South Tees occurred in March 24 with onward transmission confirmed towards the end of March. An Outbreak Control Team was established and met on 5th April 2024, with a further letter sent to parents confirming that measles was now circulating in South Tees.

4.5 Scarlet Fever and Group A Strep

Scarlet fever activity in England returned to normal seasonal levels from February 2023 and have continued so into the current 2023 to 2024 season.

4.6 HIV

England has set an ambition to end HIV transmission, AIDS and HIV-related deaths by 2030. The England HIV Action Plan 2022-25 sets out intermediate commitments to achieve the 2030 ambition, including how HIV transmission will be reduced by 80% by 2025. The monitoring and evaluation framework published in December 2022 sets out the indicators that will be used to monitor the progress towards this goal.

Some of the key metrics within Fingertips, Public Health Data from the Office for Health Improvement and Disparities can be found below.

- HIV testing rate in South Tees has significantly improved from 2020. Middlesbrough is higher at 2,424 per 100,000 compared to 1,751 per 100,000 in Redcar & Cleveland, whilst England is 2771 per 100,000.

- New HIV cases diagnosed in 2023 have increased significantly in Middlesbrough from a rate of 7.4 per 100,000 to 15.1 (23 cases). The rate in Redcar & Cleveland is significantly lower at 4.3 per 100,000. This compared to a rate of 10.4 per 100,000 in England.

- Prevalence of HIV in those aged 15-59 is significantly lower across all but Newcastle upon Tyne in the North East compared against the national rate (2.4) in 2023. Redcar and Cleveland (0.7) has the lowest prevalence rate of HIV in those aged 15-59 in the North East. However, Middlesbrough (1.61) has the 2nd highest rate in the North East and is above the regional rate (1.28).

HIV Late Diagnosis

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a PHOF indicator, and monitoring is essential to evaluate the success of local HIV testing efforts.

In the three-year period between 2021-23, of those diagnosed late with HIV, the rates per 100,000 in Middlesbrough (40.9) and Redcar & Cleveland (33.3) are lower than both the national rate (43.5).

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
HIV testing															
HIV testing rate per 100,000 population	2023	2770.7	1945.1	1738.6	1839.8	2475.2	2001.9	2423.7	2751.6	2338.4	1678.1	1751.0	1605.6	1953.8	1117.7
Proportion of TB notifications offered an HIV test <90% 90% to 100% ≥100%	2022	98.2	100	*	*	*	*	100	100	*	100	*	100	100	*
Infectious Diseases in Pregnancy Screening: HIV Coverage	2022/23	99.8*	99.8*	-	-	-	-	-	-	-	-	-	-	-	-
HIV diagnoses															
New HIV diagnosis rate per 100,000	2023	10.4	5.5	4.5	4.5	6.0	2.1	15.1	10.6	1.4	2.4	4.3	2.7	2.5	8.2
New HIV diagnoses among persons first diagnosed in the UK rate per 100,000 New data	2023	4.9	3.4	2.3	3.6	4.5	2.1	9.8	7.1	1.4	0.9	2.2	2.0	1.5	4.6
HIV late diagnosis in people first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2021 - 23	43.5	40.4	30.0	25.0	35.3	28.6	40.9	48.5	12.5	57.1	33.3	16.7	33.3	57.1
HIV late diagnosis in gay, bisexual and other men who have sex with men first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2021 - 23	34.3	34.5	50.0	33.3*	27.3*	33.3*	25.0*	52.9	0.0*	50.0*	66.7*	0.0*	50.0*	27.3*
HIV late diagnosis in heterosexual men first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2021 - 23	56.6	51.9	0.0	0.0	66.7	0.0	33.3	50.0	0.0	0.0	0.0	0.0	0.0	64.3
HIV late diagnosis in heterosexual and bisexual women first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2021 - 23	46.4	37.5	0.0	0.0	0.0	0.0	100	25.0	100	50.0	0.0	0.0	0.0	85.7
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 New data <2 2 to 5 ≥5	2023	2.40	1.28	1.02	1.25	1.58	1.01	1.61	2.47	1.11	0.77	0.70	0.92	1.16	1.20
HIV diagnosed prevalence rate per 1,000 New data <2 2 to 5 ≥5	2023	1.73	0.90	0.71	0.81	1.07	0.69	1.17	1.97	0.79	0.56	0.53	0.62	0.78	0.80

HIV treatment and care																
Determining PrEP need	2023		10.1	6.5	9.7	10.6	11.2	2.9	3.1	8.1	6.1	5.9	3.1	7.9	3.4	9.0
Initiation or continuation of PrEP among those with PrEP need	2023		73.0	57.9	59.6	64.1	60.6	47.8	41.8	61.0	62.5	49.5	37.2	68.9	47.7	65.9
Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV	2021 - 23		84.4	87.1	80.0	100	90.5	100	90.0	83.9	76.9	85.0	84.6	83.3	81.3	92.6
Antiretroviral therapy (ART) coverage in people accessing HIV care ≤ 90% 90% to ≤ 95% > 95%	2023		98.5	94.3	98.7	100.0	100.0	100.0	98.9	79.2	99.4	99.5	98.6	98.9	100.0	99.6
Virological success in adults accessing HIV care	2023		97.7	97.0	97.8	94.4	95.3	95.3	97.1	98.3	99.4	98.2	95.8	91.2	98.7	94.6

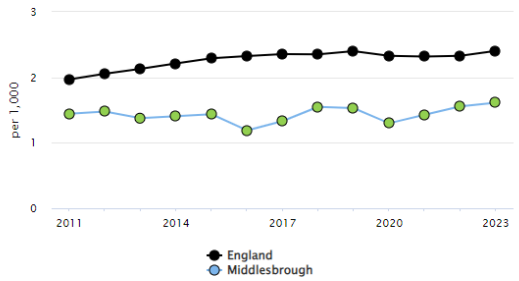
Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years by year in Middlesbrough compared to rates in the North East UKHSA Region and England: 2011 to 2023.

HIV diagnosed prevalence rate per 1,000 aged 15 to 59 **New data**

Crude rate - per 1,000

Show confidence intervals | Show 99.8% CI values

▶ More options



Recent trend: ➡ No significant change

Benchmarking against goal: <2 | 2 to 5 | ≥5

Period		Middlesbrough Count	Value	95% Lower CI	95% Upper CI	North East	England
2011		121	1.44	1.20	1.73	0.83	1.97
2012		124	1.48	1.23	1.76	0.87	2.06
2013		115	1.38	1.14	1.65	0.90	2.13
2014		117	1.41	1.16	1.69	0.95	2.21
2015		119	1.44	1.19	1.72	1.00	2.29
2016		99	1.19	0.97	1.45	1.03	2.33
2017		110	1.33	1.09	1.60	1.04	2.35
2018		127	1.55	1.29	1.84	1.09	2.35
2019		125	1.53	1.27	1.82	1.17	2.40
2020		106	1.30	1.06	1.57	1.09	2.33
2021		118	1.43	1.18	1.71	1.12	2.32
2022		134	1.56	1.30	1.84	1.17	2.33
2023		144	1.61	1.36	1.90	1.28	2.40

Source: UK Health Security Agency

In 2023, in Middlesbrough there were 144 Middlesbrough residents aged 15 to 59 years who were seen at HIV services (the prevalence of diagnosed HIV). The diagnosed prevalence per 1,000 residents aged 15 to 59 years (1.61), better than the 2.4 per 1,000 in England.

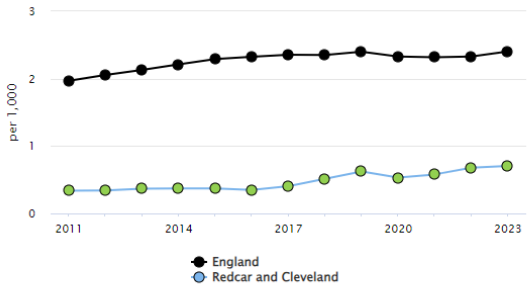
Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years by year in Redcar and Cleveland compared to rates in the North East UKHSA Region and England: 2011 to 2022.

HIV diagnosed prevalence rate per 1,000 aged 15 to 59 **New data**

Crude rate - per 1,000

Show confidence intervals | Show 99.8% CI values

▶ More options



Recent trend: ➡ No significant change

Benchmarking against goal: <2 | 2 to 5 | ≥5

Period		Redcar and Cleveland Count	Value	95% Lower CI	95% Upper CI	North East	England
2011		26	0.34	0.22	0.50	0.83	1.97
2012		26	0.34	0.22	0.50	0.87	2.06
2013		28	0.37	0.25	0.53	0.90	2.13
2014		28	0.37	0.25	0.54	0.95	2.21
2015		28	0.37	0.25	0.54	1.00	2.29
2016		26	0.35	0.23	0.51	1.03	2.33
2017		30	0.40	0.27	0.58	1.04	2.35
2018		38	0.51	0.36	0.70	1.09	2.35
2019		46	0.62	0.46	0.83	1.17	2.40
2020		39	0.53	0.38	0.73	1.09	2.33
2021		42	0.58	0.42	0.78	1.12	2.32
2022		49	0.68	0.50	0.90	1.17	2.33
2023		51	0.70	0.52	0.93	1.28	2.40

Source: UK Health Security Agency

In 2022, in Redcar & Cleveland there were 51 Redcar and Cleveland residents aged 15 to 59 years who were seen at HIV services (the prevalence of diagnosed HIV). The diagnosed prevalence per 1,000 residents aged 15 to 59 years (0.70) better than the 2.4 per 1,000 in England.

From 1st April 2023, Public Health South Tees has commissioned Terence Higgins Trust (THT) to deliver HIV prevention and HIV testing in the community.

4.7 Sexually Transmitted Infections (STIs)

As STIs are often asymptomatic, frequent STI screening of groups with greater sexual health needs is important and should be conducted in line with national guidelines. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy. Vaccination is an intervention that can be used to control genital warts, hepatitis A and hepatitis B. However, control of other STIs relies on consistent and correct condom use, behaviour change to decrease overlapping and multiple partners, ensuring prompt access to testing and treatment, and ensuring partners of cases are notified and tested.

Over the last 4 years, there has been a notable and sustained increase in syphilis infections across Teesside with 152 in 2020, 171 in 2021, 171 in 2022, and 236 in 2023. This remains a concern. Untreated syphilis can lead to further transmission and severe illness and can cause severe harm during pregnancy and in newborn babies.

Whilst syphilis cases in the UK are usually associated with men having sex with men (MSM), the syphilis outbreak in 2019 in Teesside mostly affects heterosexual men and women. The greatest number of diagnoses were among those aged 18 to 34 years.

Around half of all cases were symptomatic; others were testing because they have been identified as a contact or as part of routine sexual health testing or antenatal screening. In some cases, treatment has been delayed because symptoms such as a rash or genital ulcers were not recognised as possible syphilis.

To reduce further transmission, the Tees sexual health service provider (HCRG), working with commissioners and colleagues from the UK Health Security Agency have held several syphilis care pathways workshops from which a new a syphilis action plan has been developed. This plan will focus on increasing testing to identify cases early, timely treatment, following up with sexual partners (contacts) and focusing on improved communication for a young heterosexual audience to raise awareness. Sexual health commissioners and the provider have been involved in Outbreak Control Team meetings, in 2022-2023, independently chaired by the Consultant in Health Protection for Teesside (UKHSA). A Tees syphilis comms subgroup was established to raise awareness, with Webinars developed especially for maternity staff and comms messages pushed out for maternity staff, MSM and young people.

In the table below, the syphilis diagnostic rate in 2023 was significantly higher in Middlesbrough (46.5) and Redcar & Cleveland (33.5) compared to the England rate (16.7) or the North East rate (21.3). Middlesbrough was ranked highest in the North East and Redcar and Cleveland the 4th highest. All 4 Tees local authorities were the highest in the North East. Syphilis numbers have also been rising nationally.

Nationally there has been an increase in gonorrhoea cases diagnosed and this can be seen in Teesside also. The diagnostic rate in 2023 for Middlesbrough (146) is the 2nd highest in the North East, well above the regional rate (114) but only just below the national rate (149). Redcar and Cleveland (111)

has the 5th highest rate in the North East. Tees's sexual health service provider will use the syphilis action plan to include gonorrhoea.

Nationally, the scope of chlamydia testing has changed focusing now on reducing the harms from untreated chlamydia infection. The harmful effects of chlamydia occur predominantly in women so the opportunistic offer of asymptomatic chlamydia screening outside of sexual health services will focus on women.

Both Middlesbrough (2,658) and Redcar & Cleveland (3,327) have significantly higher Chlamydia detection rates compared to the England (1,961) and the North East (2,173) rates. Redcar & Cleveland has the 2nd highest detection rate in the region, just behind Hartlepool, and Middlesbrough has the 4th highest detection rate in the region, just behind Stockton. Teesside has the best detection rates in the North East. Despite the high prevalence of chlamydia infection, this can be taken as a positive because as more cases are detected, more cases can be treated to prevent onwards transmission.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Syphilis diagnostic rate per 100,000	2023	16.7	21.3	12.9	11.0	25.8	36.2	46.5	20.5	14.7	14.8	33.5	22.9	43.5	10.5
Gonorrhoea diagnostic rate per 100,000	2023	149	114	99	95	135	111	146	210	99	74	111	94	145	66
Chlamydia detection rate per 100,000 aged 15 to 24 (Female) <2,400 2,400 to 3,250 ≥3,250	2023	1962	2173	2096	1970	2083	3694	2658	1875	2016	1869	3327	2003	2760	1847

Source: Fingertips Data, 2023

The sexual health service has increased staffing levels to carry out more testing within the service across Tees in addition to the availability of online home sampling kits. Regular social media posts raise awareness of getting a full sexual health screen on change of partner, multiple partners or if symptomatic.

Again, from 1st April 2023, Public Health South Tees has commissioned Terence Higgins Trust (THT) to deliver STI testing in the community to extend the reach of services for those marginalised communities such as sex workers, migrants and the homeless.

4.8 Tuberculosis 3 year summary (latest data 2020-22)

Tuberculosis (TB) is an infectious disease, caused by bacteria. It is predominantly spread by the respiratory route, pulmonary TB is a notifiable disease. TB notifications are recorded on a special national electronic system that collects more than basic demographics. Analysis highlights that TB cases remain strongly associated with deprivation and that certain social characteristics are also associated with an increased risk of TB. These include alcohol misuse, drug misuse, homelessness, imprisonment, mental health needs, and asylum seeker status. TB cases diagnosed during a 3year period between 2020-22 were highest in Middlesbrough for the North East, and slightly higher than the England average. Redcar and Cleveland TB rates were significantly lower. Locally, TB cases receive treatment from the TB service at James Cook University Hospital.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
TB incidence (three year average)	2020 - 22	7.6	3.0	1.5	3.4	2.7	3.2	8.9	8.5	2.1	0.8	1.5	2.2	2.9	1.7

4.9 Healthcare associated infections at South Tees Hospitals NHS FT

The Clostridioides difficile-associated diarrhoea objective for 2023-24 was to have no more than a combined total of 110 community-onset healthcare-associated (COHA) and/or healthcare-onset healthcare-associated (HOHA) cases among patients aged over 2 years. In 2023-24 there have been 128 trust-apportioned cases. This has greatly exceeded the annual target, this equates to a 8.6% decrease compared to 2022-23.

The Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia target is that of zero tolerance. There have been 3 trust-assigned cases for the 2023-24 financial year.

There was no official Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia target for 2023-24. There were 49 Trust-apportioned MSSA bacteraemia cases in the current financial year. This compares to 42 in 2022-23.

There were 605 cases of the three Gram Negative Blood Stream Infections (GNBSI) organisms which are part of national surveillance, 141 of which were classed as HOHA and 80 of which were classed as COHA making a total of 221 trust-apportioned cases (137 E. coli, 64 Klebsiella species and 20 Pseudomonas aeruginosa). For trust-apportioned cases this is a 5% increase compared to 2022-23.

The Trust had 6 cases of bacteraemia due to Glycopeptide-resistant Enterococci in 2023-24 compared to 19 cases in 2022-2023.

Extended Spectrum Beta-Lactamases (ESBL) producing coliforms cause a large number of infections, and they are the commonest multi-drug resistant Gram-negative organisms affecting patients in the Trust and in the local community. In 2023-24 the Trust had 25 cases of bacteraemia due to ESBL-producing coliforms, compared to 112 in 2022-2023.

During the winter months, outbreaks of Norovirus infection have previously caused severe disruption both nationally and to our Trust. During 2023-24 there were 14 clusters which met our definition of an outbreak, and it affected a total of 164 patients and 98 staff members.

An international pandemic of a novel coronavirus began in December 2019. There were 50 outbreaks in our trust during the second and third waves, which met the national / regional definition. 464 staff members and 225 patients were infected during these outbreaks. After the third COVID-19 wave, we have had 100 outbreaks affecting 113 staff and 692 patients. All 100 of these outbreaks are now closed.

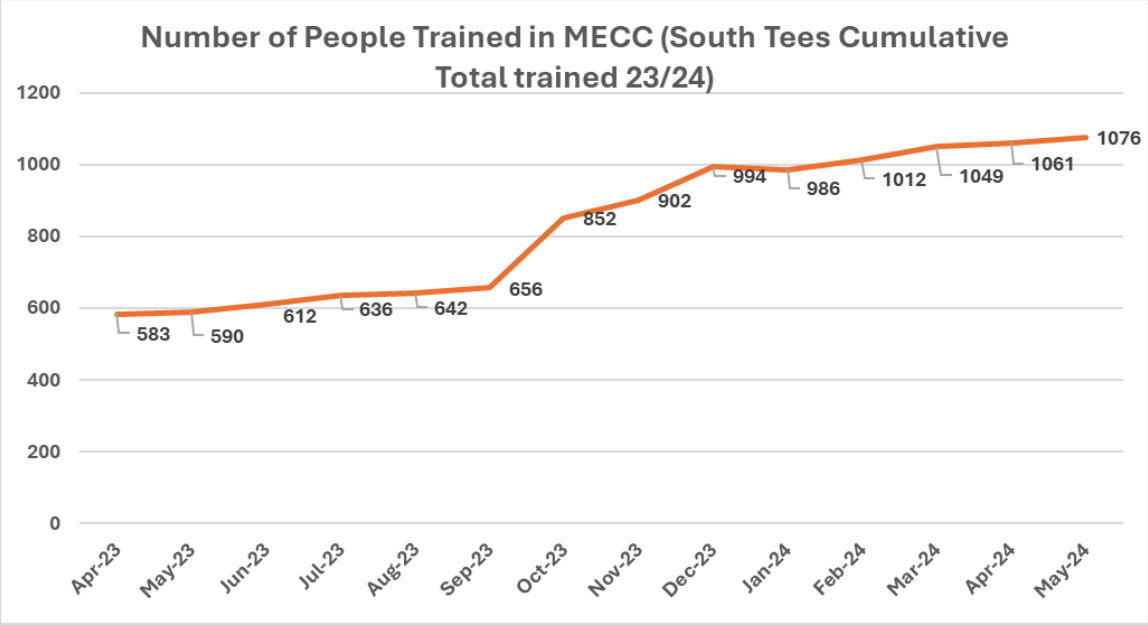
5. Community resilience

5.1 Making Every Contact Count (MECC)

Making Every Contact Count (MECC) is an evidence-based approach to behaviour change that utilises the everyday interactions that organisations and individuals have with residents to help support them to make positive changes to their health and wellbeing. There is a focus on addressing lifestyle behaviours (smoking, physical inactivity) as well as wider social determinants of health (finance, housing etc). South Tees are part of the ICB Regional MECC Steering Group.

A MECC website (www.meccgateway.co.uk/nenc) has been further developed in partnership with regional ICB to provide users with very brief intervention guidance on a wide range of health and wellbeing topics. Over the past year additional themes have been added to the website including cancer awareness and screening. An essential element of this is the facility to signpost to local health and wellbeing services as well as national support services. This has been populated with Redcar and Cleveland and Middlesbrough signposting information, including cancer awareness and immunisations.

To date **1049 people** across South Tees (Champions, Council staff, partners and volunteers) have been trained in the MECC approach (**506 during 2023-24**) and should now be utilising this in their day-to-day practice. All staff/volunteers trained in MECC are invited to join the South Tees MECC/Health Champions Network which provides a mechanism to reach communities with key health and wellbeing messages. South Tees NHS Trust have progressed MECC implementation throughout 2023-24 to further embed MECC conversations in day to day practice of all Trust staff. This has included staff training, comms campaign and embedding MECC signposting into all patient communication. Funding has been received from the ICB to appoint a personalised care coordinator to further drive this forward and they now have their own MECC Trainers to continue training.



5.2 Health Champions Network

Middlesbrough Health Champions Network (originally the Covid Champions Network) now has over **300 members** and has evolved into a South Tees network. Recruitment continues through MECC training provision, increased awareness, and involvement of VCS partners. Health protection guidance, information, and promotional messages continue to be provided to health champions, through monthly meetings and on an ad-hoc basis for dissemination across their communities or

organisations. The network approach has been recognised as a champion's best practice model regionally in partnership with Office of Health Inequalities and Disparities and best practice has been shared at regional events promoting the value of Champions and MECC. Over the last year we have had a focus on Core20+5 and have provided training in the 5 key themes to health champions and wider partners.

5.3 Core 20 Plus 5 approach

Office of Health Inequalities & Disparities (OHID) invited Middlesbrough to be part of their best practice approach with a focus on using Health Champions to address the health inequalities highlighted in the Core20PLUS5 approach (Cancer, Severe Mental Illness, Maternity, Circulatory disease, Respiratory disease). A training and awareness programme was developed across all 5 themes to allow South Tees Champions to increase their knowledge and encourage appropriate screening programmes that address these inequalities. Over 78 people attended Talk Cancer (Cancer awareness) training; 67 attended training in Severe Mental Illness; and 80 attended training in Learning Disability awareness. CVD awareness and BME maternity topics have been discussed at Health Champions Network meetings and further work on these topics is developing.

5.4 Infection Prevention Control at South Tees Hospitals NHS FT

Throughout 2023-24 there were two postholders within South Tees Hospitals NHS FT IPC Team to cover Care Homes and Domiciliary Care (from November 2023 this reduced to one staff member due to vacancy). The roles are to provide an advice, support and training service with both roles working closely in partnership with the Integrated Care Board (ICB) South, Local Authorities (LA) and Care Quality Commission (CQC).

Services include support for:

- Control, monitoring and surveillance of outbreaks with support from UKHSA regional and national experts when required.
- Provision of clinical advice and support to staff and public to identify and manage infection incidents and outbreaks.
- Auditing of IPC standards including environments and hand hygiene to an agreed criteria making recommendations for change, monitoring progress, and reporting to local authorities.
- Developing and delivering IPC education and training programmes
- Supporting and developing IPC Champions

5.5 Health Protection Assurance Workshops

In November 2023, two workshops were held to share important health protection messages and address local concerns. The first workshop was aimed at the voluntary section, workplaces and care home staff addressing adult health protection topics and the second workshop focused on youth health concerns targeting school staff, 0-19 teams and those working with young people in the community. A total of 118 people participated across the workshops with 88 people attending the workshop concentrating on youth health concerns. The purpose was to develop community wide health protection resilience ensuring that key stakeholders understand local health protection arrangements, there was also the opportunity to identify key challenges or issues faced by these settings in relation to health protection.

The agendas for each workshop followed the key themes of the Health Protection Assurance Board action plan and report, these include environmental factors, communicable diseases, increasing resilience, immunisations, and national screening programmes, with the presentations and key information sent out to delegates afterwards. Evaluations highlighted that generally, participants felt the presentations were interesting, well delivered and very informative, with a wide range of topics covered. There was a good mix of strategic and operational/community input, sharing recognition for all the hard work that has been done across South Tees.

5.6 Improving Health Protection within schools using the HealthStart approach.

Following the successful engagement, of almost all primary and secondary schools across South Tees, with the Headstart programme to improve the mental health of young people locally. It was agreed that a co-ordinated approach would be taken to improve the physical health of young people locally using a similar 'HealthStart' programme. One of the elements of this programme will focus specifically on non-communicable diseases (asthma, epilepsy, diabetes, CVD and cancer as per the core20plus5), communicable diseases (including infection prevention control), and immunisations. This will help improve community resilience by increasing knowledge, skills, and capacity to prevent and manage disease.

6. Increase equitable uptake of immunisation programmes

Immunisation remains one of the most effective public health interventions for protecting individuals and the community from serious infectious diseases. The routine childhood immunisation schedule currently offers protection against 13 different vaccine-preventable infections. In addition to the routine childhood programme, selective vaccinations are offered to individuals reaching a certain age or with underlying medical conditions or lifestyle risk factors. Due to particularly low uptake rates locally, of most immunisations on the schedule, funding was allocated by NENC ICB in Feb 2023 to address health inequalities in vaccine uptake.

6.1 Organisations roles and responsibilities

NHS England is responsible for the routine commissioning of national immunisation programmes under the Section 7a agreement of the Health and Social Care Act 2012. They commission services provided through general practice, school aged immunisation services, pharmacies and maternity services to deliver the complete routine immunisation schedule. They are responsible for ensuring local providers deliver against the national service specification and meet agreed population uptake and coverage levels as specified in the Public Health Outcomes Framework and Key Performance indicators.

UKHSA develop the Patient Group Directions (PGDs) for vaccines, they provide templates that are adapted by each region and signed off by NHS England regions. UKHSA also operate ImmForm the website for vaccine ordering and data collection on vaccine uptake.

Public Health South Tees are responsible for monitoring local vaccine uptake rates and providing independent scrutiny, where necessary challenging local arrangements and providers to increase equitable uptake among their local populations.

PCN and General Practice continues to play a key role in the delivery of vaccination programmes, including; education, promotion and delivery for patients. PCN collaborative working provides opportunities for practices to support each other in the process and provide at scale approaches when appropriate. Further information can be found in the BMA Vaccination and Immunisation Programme guidance.

Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015. Each year from September through to March the NHS runs a seasonal flu vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus. The accessibility of pharmacies, their extended opening hours and the option to walk in without an appointment have proved popular with patients seeking vaccinations. Regarding COVID-19 vaccinations, over 1,500 community pharmacy sites have been vaccinating patients and health and care workers under a Local Enhanced Service against coronavirus alongside vaccination centres, hospitals and Primary Care Network (PCN) sites.

Other key partners who contribute to the delivery of immunisations include school aged immunisation service, sexual health service and occupational health services.

6.2 Childhood Immunisations

Population vaccination coverage is a key outcome measure in the Public Health Outcomes Framework. For 2023/24 Middlesbrough did not meet the national target of 95% for all 13 indicators listed (see table below). Uptake rates are particularly low for Hib and MenC booster, PCV and MMR. For 2023/24 Redcar & Cleveland did not meet the national target of 95% for 8 of the 13 indicators listed (see below).

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Population vaccination coverage: Hepatitis B (1 year old) New data	2023/24	*	*	-	-	*	-	100	100	-	*	-	-	*	100
Population vaccination coverage: Dtap IPV Hib HepB (1 year old) New data <90% 90% to 95% ≥95%	2023/24	91.2	95.2	96.4	94.7	94.0	92.9	91.3	92.6	96.7	96.8	94.7	97.0	95.5	96.9
Population vaccination coverage: PCV New data <90% 90% to 95% ≥95%	2023/24	93.2	96.9	97.4	95.5	96.6	96.7	94.2	95.7	97.9	97.6	96.4	97.7	96.9	97.9
Population vaccination coverage: Hepatitis B (2 years old) New data	2023/24	*	*	80.0	100	*	-	100	76.5	-	-	*	*	*	*
Population vaccination coverage: Dtap IPV Hib HepB (2 years old) New data <90% 90% to 95% ≥95%	2023/24	92.4	95.8	97.5	94.7	95.4	93.8	91.4	93.7	97.0	97.4	94.8	97.1	95.0	96.9
Population vaccination coverage: Hib and MenC booster (2 years old) New data <90% 90% to 95% ≥95%	2023/24	88.6	93.6	95.9	92.4	92.8	93.2	86.2	90.9	95.9	95.8	92.7	96.2	93.1	94.5
Population vaccination coverage: PCV booster New data <90% 90% to 95% ≥95%	2023/24	88.2	93.3	95.5	91.9	92.4	93.0	85.6	90.6	95.3	95.7	93.0	95.7	93.0	93.9
Population vaccination coverage: MMR for one dose (2 years old) New data <90% 90% to 95% ≥95%	2023/24	88.9	93.9	95.7	91.9	94.4	93.5	86.9	91.3	96.0	96.0	92.7	96.3	93.3	94.7
Population vaccination coverage - Hib / Men C booster (5 years old) <90% 90% to 95% ≥95%	2017/18	92.4	95.1	97.2	96.0	93.2	94.5	90.1	90.9	96.3	95.7	95.3	97.6	96.0	97.1
Population vaccination coverage: MMR for one dose (5 years old) New data <90% 90% to 95% ≥95%	2023/24	91.9	95.1	97.0	93.1	95.0	96.4	88.4	92.8	96.1	96.8	95.7	96.8	95.4	95.3
Population vaccination coverage: MMR for two doses (5 years old) New data <90% 90% to 95% ≥95%	2023/24	83.9	89.7	94.2	87.9	86.8	89.2	77.9	85.2	91.7	92.5	89.1	93.7	89.7	90.9
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) <80% 80% to 90% ≥90%	2022/23	71.3	70.5	68.6	71.2	73.8	58.8	53.1	65.8	84.9	76.5	68.1	73.3	67.9	76.3
Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years) <80% 80% to 90% ≥90%	2021/22	79.6	78.5	73.0	71.8	89.7	65.4	51.2	86.8	91.4	88.4	69.0	80.7	77.8	78.8

During 2022-23, North East North Cumbria ICB allocated health inequalities funding proportionately to all local authorities in the region to increase immunisation uptake rates. Part of the funding allocated to Middlesbrough was used to commission behavioural insights work into uptake of childhood immunisations, recommendations from the evaluation will be implemented across South Tees.

6.3 Adolescent Immunisations

Adolescents are offered the Human Papilloma Virus vaccine in Y8 to protect against different types of cancers and genital warts. In Year 9, they are offered the final booster for Diphtheria, Tetanus and Polio vaccine and they are offered the Meningitis vaccine (MenACWY) to protect against strains A, C, W, & Y of the disease.

HPV vaccine uptake rates in Middlesbrough were better in 2022-23 than in 2021-22, with first dose uptake for males increasing from 31.5% to 45.5% and females increasing from 40.3% to 53.1%, both were much lower than the England averages of 65.2% and 71.3% respectively. The trend of females having higher uptake rates than males continued for the second dose in Year 9 where uptake dropped from 26.1% to 20.8% for males and dropped from 31.8% to 26.1% for females, compared to the England average which also dropped from 62.4% to 56.1% for males and from 67.3% to 62.9% for females.

HPV vaccine uptake rates in Redcar & Cleveland were also better in 2022-23 than in 2021-22, with first dose uptake for males increasing from 36.1% to 56.5% and females increasing from 42.1% to 68.1%, compared to the England averages of 65.2% and 71.3% respectively. The trend of females having higher uptake rates than males continued for the second dose in Year 9 where uptake dropped from 34.6% to 29.3% for males and dropped from 41.0% to 34.2% for females, compared to the England average which also dropped from 62.4% to 56.1% for males and from 67.3% to 62.9% for females.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Male) <80% 80% to 90% ≥90%	2022/23	65.2	64.1	60.4	65.4	69.0	58.3	45.5	57.8	80.8	71.2	56.5	71.0	53.2	76.6
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female) <80% 80% to 90% ≥90%	2022/23	71.3	70.5	68.6	71.2	73.8	58.8	53.1	65.8	84.9	76.5	68.1	73.3	67.9	76.3
Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old) (Male) <80% 80% to 90% ≥90%	2022/23	56.1	48.2	31.8	35.2	66.9	23.0	20.8	57.4	61.2	71.7	29.3	72.4	30.1	59.5
Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old) (Female) <80% 80% to 90% ≥90%	2022/23	62.9	54.9	43.6	48.3	72.1	36.1	26.1	57.7	67.9	74.6	34.2	71.6	40.2	69.1

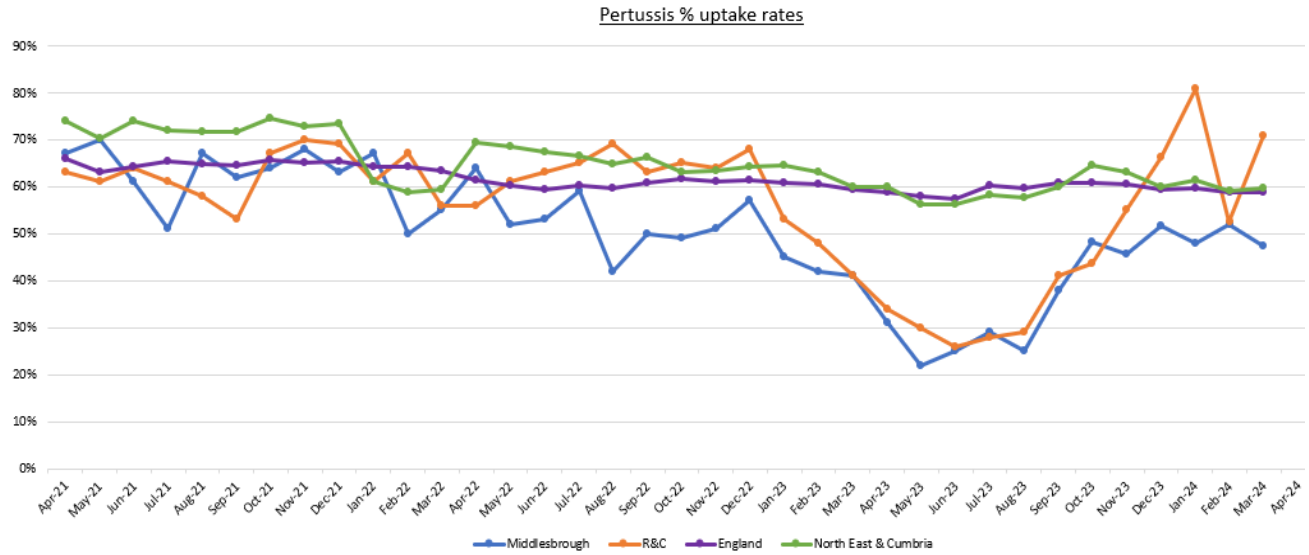
Uptake data for MenACWY has not yet been refreshed for 2022-23.

Following the successful adolescent immunisations behavioural insights trial at MacMillan Academy, Middlesbrough in 2022-23, the multi-agency partnership was widened to include partners from Redcar & Cleveland, Hartlepool and Durham in 2023-24 to trial a range of interventions based on the premise that "uptake of school age immunisations is below national targets because parents are not completing consent forms for their children due to lack of capability, opportunity, and motivation to do so". The trial evaluation found that without any additional effort or activity, the delivery of the right messages at the right times appears to consistently 'nudge' parents to return their consent

form. A number of recommendations have now been provided, we will continue to work with the new School Aged Immunisation Service provider to implement these across all schools in South Tees.

6.4 Pregnant Women Immunisations

Between 16 and 32 weeks of pregnancy, pregnant women are eligible to receive a pertussis vaccine, this protects babies against whooping cough, which in babies can lead to complications resulting in hospitalisation and even death. The number of babies infected with whooping cough has fallen since the vaccination in pregnancy was introduced however, pregnant women still need to be vaccinated because the disease remains at high levels in older children and adults.



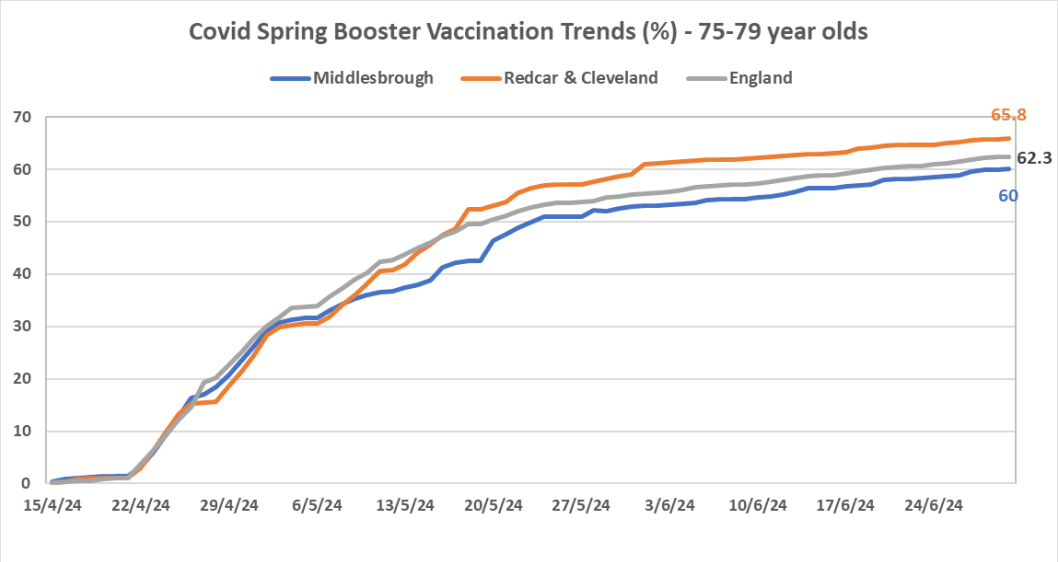
If women are pregnant during the flu season, they will also be offered the flu vaccine which protects both the mother and her unborn baby against flu for the whole flu season – even after the baby has been born. Flu uptake rates among pregnant women in South Tees dropped significantly for the 23-24 flu season. Using a small proportion of the NENC inequalities funding, we developed resources to increase both flu, covid and pertussis immunisation uptake rates in pregnant women. After success of the resources in South Tees NHS Trust, the resources have been shared regionally, and can be viewed here.

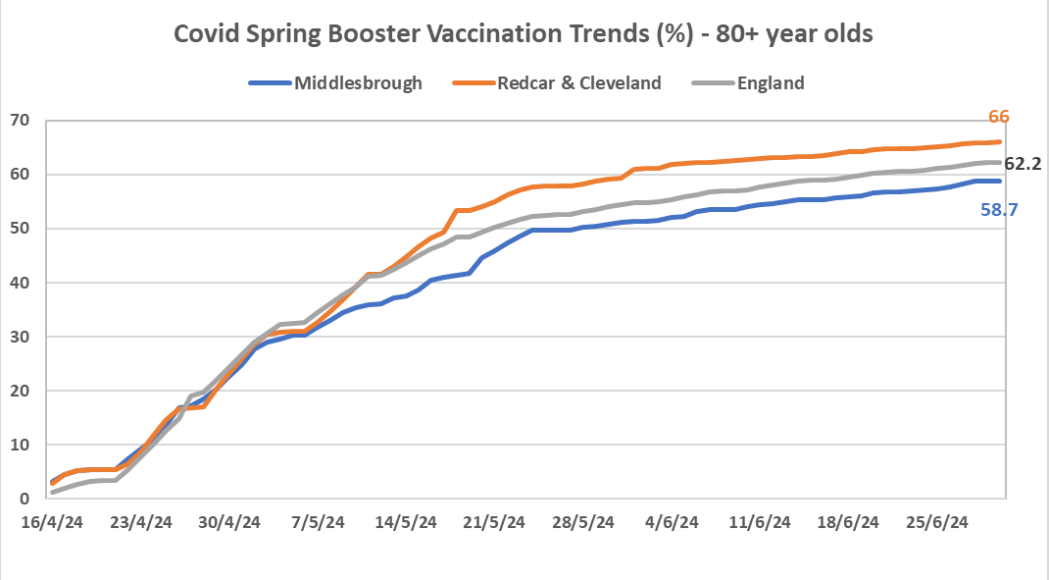
Pregnant women (flu vaccine uptake)	Middlesbrough	Redcar & Cleveland	England
2021-22	39.6%	49.7%	37.9%
2022-23	25.3%	34.9%	35.0%
2023-24	30.0%	39.7%	32.1%

6.5 Covid-19 Immunisations

The covid-19 vaccine provides safe and effective protection against covid-19. The whole population (age 12 up) were eligible for doses 1 and 2. The subsequent booster programmes have been and will continue to be offered to those who meet the eligibility criteria, those who are most vulnerable and therefore require additional vaccines to ensure continued protection.

The graphs below show the latest Covid-19 spring booster vaccination uptake rates (April to June 2024). Redcar & Cleveland had higher uptake rates for both 75-79 and 80+ year old age groups compared to England, whilst Middlesbrough had lower uptake rates.





Source – UKHSA Covid-19 Dashboard

6.6 Flu Immunisations

Seasonal influenza (flu) is an unpredictable but recurring pressure that the NHS faces every winter. Vaccination offers the best protection. For most healthy people, flu is an unpleasant but usually self-limiting disease with recovery generally within a week. However, there is a particular risk of severe illness from catching flu for older people, the very young, pregnant women, those with underlying disease or long-term conditions and those who are immunosuppressed. It is those at-risk cohorts who are offered the free flu vaccine each year between September and February.

Uptake rates among those aged 65 and over are above the 75% for both Middlesbrough and Redcar & Cleveland. England and all North East LAs are under the 55% target for at risk individuals, with Middlesbrough lowest at 39% in North East. Vaccination of the very young and school children could be improved across South Tees.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Population vaccination coverage: Flu (aged 65 and over) New data <75% ≥75%	2023/24	77.8	80.0*	81.0	79.7	80.1	75.6	75.9	78.9	81.7	81.7	81.8	79.0	80.2	78.0
Population vaccination coverage: Flu (at risk individuals) New data <55% ≥55%	2023/24	41.4	43.7*	45.4	43.8	43.8	39.2	35.8	41.7	45.9	48.3	44.8	44.0	42.7	41.3
Population vaccination coverage: Flu (2 to 3 years old) New data <40% 40% to 65% ≥65%	2023/24	44.4	45.8*	51.7	49.7	47.2	38.1	33.0	42.5	50.9	50.0	43.4	44.7	46.2	40.8
Population vaccination coverage: Flu (primary school aged children) New data <65% ≥65%	2023	55.1	52.6*	54.5	44.9	58.7	42.7	31.3	52.0	63.5	63.9	44.8	52.4	44.6	54.7

6.7 Older Adults Immunisations (latest data)

Adults aged 65 are offered the pneumococcal vaccine that protects against 23 types of pneumonia, which can lead to sepsis and meningitis and can be fatal. Then between the ages of 70-79 adults are offered the shingles vaccine which helps to reduce the risk of getting shingles and if you do go on to have the disease the symptoms may be milder and shorter. Uptake of the Pneumococcal vaccine was above 70% for both Middlesbrough and Redcar & Cleveland. However, shingles vaccine uptake rates were 48% in Middlesbrough and 56% in Redcar & Cleveland, so these could be improved.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Population vaccination coverage: PPV New data <65% 65% to 75% ≥75%	2022/23	71.8	75.1	74.6	78.3	80.3	64.1	71.5	76.7	73.8	75.2	72.7	77.4	74.0	77.0
Population vaccination coverage: Shingles vaccination coverage (71 years) New data <50% 50% to 60% ≥60%	2022/23	48.3	52.6	52.5	60.5	53.4	47.7	48.3	49.5	55.9	50.0	55.8	55.8	57.8	49.9

7. Increase equitable uptake of screening programmes

Screening remains one of the most effective public health interventions for protecting individuals and the community from serious illness. Following the transition of responsibilities from Public Health England (PHE) to NHS England (NHSE) in October 2021, publication of screening data for the 11 NHS Screening Programmes is now predominantly carried out by NHS England. In addition to the routine antenatal and newborn screening programme, selective screening programmes are offered to individuals reaching a certain age or with underlying medical conditions or lifestyle risk factors such as abdominal aortic aneurysm (AAA) and bowel, breast, cervical and diabetic eye screening.

7.1 Organisations roles and responsibilities

NHS England is responsible for the routine commissioning of national screening programmes under the Section 7a agreement of the Health and Social Care Act 2012. They commission services provided through regional screening centres, general practice, school nurses, and maternity services to deliver the complete routine screening schedule. They are responsible for ensuring local providers deliver against the national service specification and meet agreed population uptake and coverage levels as specified in the Public Health Outcomes Framework and Key Performance indicators.

Public Health South Tees are responsible for monitoring local screening uptake rates and providing independent scrutiny, where necessary challenging local arrangements and providers to increase equitable uptake among their local populations.

PCN and General Practice continues to play a key role in the delivery of screening programmes, including education, promotion and delivery for patients. PCN collaborative working provides opportunities for practices to support each other in the process and provide at scale approaches when appropriate.

NECS is responsible for the Cervical Screening Administration Service and supports the National Cervical Screening Programme by: providing Prior Notification Lists (PNLs) of patients eligible for screening to GP practices, sending out call and recall letters to patients eligible for cervical screening tests and notifying patients of test results once received from laboratories. Sexual Health Services also carry out cervical screening.

7.2 Increasing equitable uptake of screening programmes

As screening programmes are designed to detect ill health at the earliest possible opportunity, and increase likelihood of survival, it is of paramount importance that local authorities challenge screening providers to ensure that there is equitable uptake of these programmes across the local population, with particular focus being placed on traditionally underserved groups. This will help to ensure that inequalities not only in screening but in subsequent treatment, health outcomes and life expectancy are not being perpetuated. The most effective way to mitigate these inequalities, is to carry out a health equity audit, analysing local data about those who do not engage with initial screening processes or who do not attend follow up appointments when anomalies have been detected, and therefore do not complete the screening process. This can help to design interventions to specifically target those, who for complex reasons, do not usually engage.

7.3 Antenatal and Newborn Screening Programmes (latest data)

Antenatal screening programmes aim to detect genetic disorders and infectious diseases (such as HIV, Hepatitis B and Syphilis) that can be passed on the unborn baby, along with foetal anomalies. Following the birth babies are screened to assess the wellbeing (hearing, physical examination and blood spot). The aim of antenatal and newborn screening is to spot any problems early so that treatment can be started as soon as possible. Hearing screening coverage is lower in South Tees.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Newborn Hearing Screening: Coverage	2022/23	98.5*	99.0*	98.2	99.5	99.4	99.2	97.8	99.4	99.5	99.2	97.8	99.7	99.5	99.0
Newborn and Infant Physical Examination Screening Coverage	2022/23	96.2*	95.8*	94.6	94.2	96.3	98.4	96.6	95.1	95.5	96.6	95.8	95.7	97.5	96.2

7.4 Childhood Screening Programmes

The National Child Measurement Programme (NCMP) takes height and weight measurements of children in reception and year 6. The prevalence of overweight (including obesity) in Middlesbrough rises from 30% in reception to 40% in year 6 and in Redcar & Cleveland from 27% in reception to 39% in year 6.

The NCMP letters have all been adapted to include more local information about support which is readily available to families across South Tees. This includes a variety of HENRY programmes offered alongside implementation of the South Tees Eat Well Schools Award and the South Tees Eat Well Early Years Award that will be offered to all schools as an element of the HealthStart Programme.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Reception prevalence of overweight (including obesity) (4-5 yrs) New data	2023/24	22.1	24.7	26.7	23.3	21.8	27.9	29.7	24.0	22.3	24.7	27.0	22.6	22.3	23.9
Year 6 prevalence of overweight (including obesity) (10-11 yrs) New data	2023/24	35.8	38.6	37.8	35.4	37.5	41.6	39.8	40.6	36.8	35.2	38.9	40.1	38.6	42.3

7.5 Adult Screening Programmes

Men and women aged over 60 years are currently invited to participate in the national **bowel screening programme** every 2 years. This is gradually being extended to include everyone aged 50 to 59 years by April 2025. In 2023, coverage rates for Middlesbrough were 67.9% and for Redcar & Cleveland were 72.9%. There is currently a 'Reducing inequalities in uptake of bowel screening' project being led by North Tees NHS FT, where partners from across Tees are working to reduce drop out at all stages of the bowel screening process.

Women aged 50-71 are currently invited to participate in the national **breast screening programme** every 3 years. In 2023, coverage rates for Middlesbrough were 63.6% and for Redcar & Cleveland were 66.7%. A breast screening health equity audit for the North-East and North Cumbria is being planned and led by OHID.

Women aged 25-49 are currently invited to participate in the national **cervical screening programme** every 3 years. In 2023, coverage rates for Middlesbrough were 60% and for Redcar & Cleveland were 73.9%. Women aged 50-64 are currently invited to participate in the national cervical screening programme every 5 years. In 2023, coverage rates for Middlesbrough were 69.9% and for Redcar & Cleveland were 74.9%. As part of the current behavioural insights work, previous cervical screening interventions are being reviewed and refreshed

Abdominal Aortic Aneurysm (AAA) screening is offered to men aged 65, the screening detects weakness in aorta (the main blood vessel that runs from the heart through your abdomen), which can then be treated to prevent the vessel bursting and causing death. In 2022/23 coverage rates for Middlesbrough were 75.1% and for Redcar and Cleveland were 84.1%.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
C24a - Cancer screening coverage: breast cancer	2023	66.2*	67.1*	69.4	71.7	67.6	65.6	63.6	58.0	57.2	70.5	66.7	69.6	69.0	70.9
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	2023	65.8*	70.8*	74.8	73.2	72.7	71.8	60.0	59.6	74.8	75.0	73.9	74.1	72.8	70.5
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	2023	74.4*	75.6*	76.6	76.9	75.6	72.7	69.9	73.9	76.1	77.4	74.9	75.2	75.0	76.3
C24d - Cancer screening coverage: bowel cancer	2023	72.0*	74.0*	74.6	73.9	74.1	70.0	67.9	72.6	75.4	78.6	72.9	72.3	72.2	73.7
C24e - Abdominal Aortic Aneurysm Screening Coverage	2022/23	78.3*	77.7*	81.7	82.6	81.7	70.0	75.1	71.8	67.3	74.1	84.1	78.8	79.5	81.9

NHS Health Checks are offered to all adults aged 40 -74 once every 5 years, the check can help spot early signs of stroke, kidney disease, heart disease, type 2 diabetes, or dementia in people who do not have pre-existing conditions. Public Health South Tees in partnership with Stockton and Hartlepool currently commission GP practices to deliver the NHS Health Check service, following the disbanding of the Community Nurse Bank led service at the beginning of the pandemic in 2020.

Indicator	Period	England	North East region (statistical)	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
People invited for an NHS Health Check	2020/21 Q1 - 2024/25 Q1	57.9	54.2	84.7	100*	60.0	50.1	42.4	11.3	48.9	37.2	51.0	27.2	44.4	67.0
People receiving an NHS Health Check	2020/21 Q1 - 2024/25 Q1	22.7	19.8	24.3	46.1	18.5	17.7	21.4	5.2	23.9	16.8	22.3	11.4	20.3	19.1
People taking up an NHS Health Check invite	2020/21 Q1 - 2024/25 Q1	39	36	29	41	31	35	51	45	49	45	44	42	46	29

Public Health South Tees attend PCN practice managers to promote NHS Health Checks and ensure all necessary documentation is in place. In addition to mandated NHS Health Checks, InHIP funding has enabled the Academic Health Science Network to conduct CVD prevention research in Middlesbrough. The research applied a behavioural insights approach to explore ethnic minority and underserved groups' experience of CVD heath check uptake in the north-east of England. Findings from this research will be used to design interventions to increase equitable uptake of these checks.

8. Recommendations for health protection across South Tees

The Health Protection Assurance Report sets out the current situation with regards to environmental issues, communicable diseases, community resilience, immunisations and screening programmes, the following are recommendations for work to be commenced across the local system during 2024-25.

8.1 Protection from environmental hazards

a) Monitor implementation of the South Tees Clean Air Strategy.
b) Implement the third Selective Landlord Licensing area in Middlesbrough.
c) Ensure that severe weather alerts are cascaded in line with the South Tees Severe weather plan.

8.2 Prevention of communicable diseases and outbreaks

a) Develop a new model for sexual health services based on the findings of the needs assessment and service review, proceed to recommission new sexual health services from August 25.
b) Work with UKHSA to review epidemiological data of syphilis to enable the development of a local action plan.
c) Develop local campaigns using behavioural insights to increase condom use.
d) Increase BBV testing with a key focus on vulnerable groups.
e) Monitor the implementation of the local syphilis action plan aimed to increase testing.
f) Annually review and update the South Tees Outbreak Management Strategy and Outbreak Policy.

8.3 Community resilience

a) Continue to promote the communicable disease and immunisation element of HealthStart.
b) Annual workforce development plan implemented for wider council and key partners to increase health protection capacity across the councils.
c) Offer immunisation and screening training to MECC champions.
d) Develop a programme to reduce unintended pregnancies (Middlesbrough has the highest rates in England).
e) Hold the annual South Tees Health Protection Workshops.
f) Continue to grow the health champions' network and establish community feedback channels to understand community needs, perceptions, and experiences with public health services.
g) Community-Based Education Programs**:** work with community organisations to develop educational initiatives targeting health literacy, vaccination awareness, and preventive health behaviours.

8.4 Increase equitable uptake of immunisations

a) Contribute to the new Tees Valley Local Immunisation Steering Group and Tees Valley Immunisation Strategy.
b) Following completion of the trial, implement the effective 0-5 imms resources across South Tees.
c) Following completion of the trial, work with the School Aged Immunisation Service to implement the effective adolescent immunisation resources across South Tees.
d) Collaborate with Maternity Services at South Tees Hospitals NHS FT to increase uptake of pertussis, RSV, covid-19 and flu vaccinations in pregnant women.
e) Deliver Staff Hep B immunisations to front line local authority staff who work closely with at risk population groups.
f) Offer vaccine awareness raising sessions to wider system partners, especially those working with vulnerable groups, who have a role in improving vaccine uptake rates across South Tees.

8.5 Increase equitable uptake of screening programmes

a) Contribute to the review and roll out of cervical screening resources across South Tees and the North East.
b) Commission targeted work to improve cervical screening uptake in practices with low coverage, providing support to implement behavioural science informed resources, contact non-attenders, and increase capacity where needed.
c) Recommission the NHS Health Check programme standardising the approach to quality assurance, targeted engagement, data management, and training.
d) Continue to support the Tees Bowel Screening inequalities workstream.
e) Offer screening awareness raising sessions to wider system partners, especially those working with vulnerable groups, who have a role in improving screening uptake rates across South Tees.
f) Look to implement local Health Equity Audits on nationally led screening programmes to ensure health inequalities are being addressed through behavioural insights informed interventions.

8.6 Health Protection Assurance Report for 2023-24 approval

Mark Adams
Joint Director of Public Health
Date: 11/10/2024

South Tees Health and Wellbeing Executive Assurance Report

To:	Live Well South Tees Health and Wellbeing Board	**Date:**	January 2025
From:	Kathryn Warnock on behalf of South Tees Health and Wellbeing Executive	**Agenda**	Item 7
Purpose of the Item	To provide Live Well 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 Live Well 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 was established. This is now a sub-section of the South Tees ICB Place Committee. 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 details of progress the Health and Wellbeing Executive has made against the Board's statutory functions.

3.2.1 Better Care Fund (BCF) 2025/26

At the time of writing, the BCF policy framework, planning requirements and confirmation of national minimum funding contributions for 2025/26 are yet to be released, having been expected in December 2024.

Indications are that the principles for the 2025-26 BCF Policy Framework will be:

- To support the government's Health Mission and the shift to a "neighbourhood health" approach
- To better support patients and service users by enabling people to live more healthy and independent lives for longer
- To support hospital flow and positively contribute to the NHS' ability to move towards constitutional standards
- To make the BCF work better for local authorities and the NHS by reducing administrative burdens and providing greater flexibility in to meet BCF priorities

The BCF Implementation and Monitoring Group will continue to work collectively to fulfil all planning requirements including allocation of funding. Formal approval of plans will be sought from the Live Well South Tees Board.

3.2.2 **BCF 2024/25 Quarter 2 Reporting Templates**

The national team required updates in quarter 2 to confirm performance against metrics, actual expenditure to date and a review of hospital discharge and community activity and capacity.

The templates were completed and submitted by the BCF Implementation and Monitoring Group by the deadline of 31st October 2024, with delegated Health and Wellbeing Board approval.

Members are asked to **note** submission of these templates which are attached as appendices a) and b).

Reporting templates for quarter 3 have now been released with a deadline for submission of 14th February 2025. These will be included in the next Executive Assurance Report.

3.2.3 **Health Protection**

The South Tees Health Protection Assurance Partnership has approved the Communicable Disease Outbreak Management Plan (OMP), to provide a structured and effective approach to managing infectious disease outbreaks. The plan seeks to protect the health of the local population, prevent the spread of disease, and ensure a coordinated, timely response by all stakeholders. The plan has been developed by Public Health South Tees in line with the UK Health Security Agency (UKHSA) Guidance: Communicable disease outbreak management: operational guidance and the North East Outbreak Control Plan which is agreed between UKHSA, the twelve North East Local Authorities, and the North East Local Health Resilience Partnership.

Local Authorities and key partners have an ongoing statutory responsibility to have local Outbreak Management Plans for responding to emergencies in their areas as part of their existing duty for safeguarding and protecting the health of their population. The last Middlesbrough and Redcar & Cleveland outbreak management plans were developed in June 2020 in response to the global outbreak of covid-19. The primary aim of the OMP is to minimise the impact of communicable diseases on the health and well-being of the people in South Tees by implementing effective prevention, identification, and containment strategies. The plan is available on request Rebecca_scott@middlesbrough.gov.uk

3.2.4 **Pharmaceutical Needs Assessment**

The next Pharmaceutical Needs Assessment (PNA) is due to be published October 2025. The Health and Wellbeing Executive have agreed to delegate responsibility to the PNA Steering Group and will receive updates by exception as required.

PROGRESS AGAINST LIVE WELL SOUTH TEES BOARD PRIORITIES

4.1 Set out below is a summary of the progress the Executive has made towards achieving the Board's priorities since the last Board meeting and of important matters arising.

4.2 **Forward Work Programme**

The Forward Work Programme will be developed after agreements at the Live Well South Tees Board meeting.

Outlined below are the statutory functions of the Health and Wellbeing Board.

Area of Focus	Lead Organisation/ System Group	Agenda Item Live Well South Tees Board	HWB Executive Assurance Report
Statutory Functions			
BCF Plans and Additional Discharge Funding Quarterly and End of Year Returns	BCF Implementation and Monitoring Group South Tees Executive Governance Board	As required by national timelines	Updates for each Board meeting
Children's Safeguarding Board Reports	South Tees Safeguarding Children Partnership	To be confirmed	
Director of Public Health's Annual Report	Public Health	To be confirmed	
Healthwatch Update	Healthwatch	As required	Quarterly updates
Health Protection Assurance Report	Public Health	January 2025	
Joint Strategic Needs Assessment Updates	JSNA Project Board	As required	
Pharmaceutical Needs Assessment – Endorsement and Noting of Any Issues	PNA Steering Group	As required	March 2025
Teeswide Safeguarding Adults Board (TSAB) Annual Report	TSAB	March 2025	

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	APPENDICES

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

6.2 **Appendices:**

Appendix a) : Middlesbrough BCF 2024-25 Quarter 2 Reporting Template
Appendix b) : Redcar & Cleveland BCF 2024-25 Quarter 2 Reporting Template

Contact Officer
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Better Care Fund 2024-25 Q2 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

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

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

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

Checklist (2. Cover)

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

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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met,an outline of the challenge and mitigating actions to support recovery should be outlined. it is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- Not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.
Activity
'For reporting across 24/25 we are asking HWB's to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs particularly for winter and ongoing data issues.
5.2 C&D H1 Actual Activity
Please provide actual activity figures for April - September 24, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.
The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

Better Care Fund 2024-25 Q2 Reporting Template

2. Cover

Version 3.6

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist
Health and Wellbeing Board:	Middlesbrough	Complete:
Completed by:	Kathryn Warnock	Yes
E-mail:	kathryn.warnock@nhs.net	Yes
Contact number:	07766554805	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	No
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

Better Care Fund 2024-25 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Middlesbrough

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q2 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Middlesbrough

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please: - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	284.1	185.2	225.8	191.3	300.7	Not on track to meet target	Q1 saw a higher than expected regional rate of admissions, but early Q2 data shows an improvement. The challenges are our demographics which are well recognised. We don't have any support needs at this stage.	Our BCF funded admission avoidance and prevention schemes, such as our support to care home schemes, continue to contribute to reduce unplanned admissions, alongside wider initiatives such as UCR and hospital at home.	We will review this after we receive Q2 data, but STHFT and NTHFT are currently still submitting Same Day Emergency Care (SDEC) activity to Inpatients. However, the removal of this activity to ECDS was reflected in our Avoidable Admissions and Falls plans	We are only slightly over target so feel that the initiatives we have in place will help us achieve the target year end We will continue to collectively monitor performance throughout the year through review of BI information and at regular meetings.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.5%	92.5%	92.4%	92.5%	89.73%	On track to meet target	Although slightly under target for Q1 we hope this will improve in Q2. We have not identified any particular challenges or support needs and are confident in our joined up processes to facilitate discharges.	We have numerous schemes and initiatives in place to support this metric including our Transfer of Care Hub, Home First Service and increased reablement capacity.	Our ongoing implementation of discharge to assess could potentially mean fewer people are discharged straight from hospital to 'home' but maximises their potential to return home after the assessment period.	Not required	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,778.6	432.1	On track to meet target	We were over target in Q1 but hope this will improve in Q2. We don't have the latest data at this stage. No particular challenges or support needs identifed.	We continually aim to reduce emergency admissions due to falls through our BCF funded initiatives such as assistive techology and support to care homes and through the joint plans being developed around falls prevention. We have a South Tees falls prevention strategy in place with a clear action plan to make preventing falls 'everyone's business' and we have a 'Steady on Your Feet' self-assessment on line tool.	N/A	Not required	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	766				not applicable	On track to meet target	Performance is better than planned.	A scheme of delegation has been put in place and is working effectively which is why we are seeing a reduction in residential placements. In addition we continue to support independence and our priority is the home first option on discharge. BCF services that support this include Reablement, Discharge to Assess and use of Technology and the Transfer of Care Hub.	N/A	Not required	Yes

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Middlesbrough

5.1 Assumptions

1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.	Checklist Complete:
Estimates for capacity and demand are as predicted. There is fluctuation in demand but this is within anticipated levels. Increased capacity and efficiency in our Home First Service has enabled more referrals to be taken for reablement at home. We are seeking some dedicated BI support to help with capacity and demand planning.	Yes
2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?	
We have a weekly operational meeting with colleagues from the acute hospitals, ICB, NECS and neighbouring Local Authorities. This responds to any challenges in terms of demand and capacity and manages winter surge activity. Strategically we have the South Tees Strategic Oversight Group which will support with escalation as required. Our multi-agency Transfer of Care Hub continues to support with safe, appropriate and timely discharges from hospital which helps to free up capacity and BCF and Discharge Fund investment in reablement services supports with discharges and admission avoidance. We continue to fund a Discharge to Assess period for patients in pathways 1 and 2 from the Discharge Funding available until March 2025.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
None identified currently.	Yes
4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
Our commissioning model allows for flexibility to support periods of peak demand - this applies to our residential rehabilitation model in addition to our domiciliary and residential care market.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6 months of the year
- modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Middlesbrough

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through only spot purchasing (doesn't apply to time to service)					
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	43	45	43	43	41	43	50	46	50	60	46	49	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2						
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	70	72	70	72	72	70	71	71	73	59	70	53	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1						
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	14	14	14	13	13	13	32	26	27	19	17	21	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	3	3	3	3	3	3	3	3	3	3	3	3						
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	40	43	41	41	39	41	40	49	35	42	48	36	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2						
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0						

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:					
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**
Social support (including VCS)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	Monthly activity. Number of new clients.	550	561	586	592	597	602	500	557	635	583	504	631
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	36	37	36	37	37	36	33	28	18	26	20	16
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	10	10	10	10	10	10	7	3	3	2	2	4
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Yes
Yes
Yes
Yes
Yes

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Middlesbrough

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£2,473,957	£1,032,236	41.72%	£1,441,721
Minimum NHS Contribution	£15,013,367	£7,136,740	47.54%	£7,876,627
iBCF	£8,645,870	£4,322,935	50.00%	£4,322,935
Additional LA Contribution	£1,412,354	£478,344	33.87%	£934,010
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£2,020,229	£1,079,125	53.42%	£941,104
ICB Discharge Funding	£1,556,799	£731,182	46.97%	£825,617
Total	**£31,122,576**	**£14,780,562**	**47.49%**	**£16,342,014**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25 Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,254,189	£1,914,640	£2,339,549
Adult Social Care services spend from the minimum ICB allocations	£8,367,590	£4,898,882	£3,468,708

Checklist Column complete: Yes Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
1	Recovery & Reablement - Community	Community equipment	Assistive Technologies and Equipment	Community based equipment		694	344	Number of beneficiaries	Social Care		NHS			Local Authority	Minimum NHS Contribution	£171,600	£85,800	
1	Recovery & Reablement - Community	Telecare equipment /support	Assistive Technologies and Equipment	Other	Staffing costs	0	NA	Number of beneficiaries	Social Care		NHS			Local Authority	Minimum NHS Contribution	£104,200	£52,100	
1	Recovery & Reablement - Community	Reablement Brokerage	Bed based intermediate Care Services (Reablement,	Other	Reablement Brokerage staffing costs	0	NA	Number of placements	Social Care		NHS			Local Authority	Minimum NHS Contribution	£24,950	£12,475	
1	Recovery & Reablement - Community	Reablement Brokerage	Home-based intermediate care services	Other	Reablement Brokerage staffing costs	0	NA	Packages	Social Care		NHS			Local Authority	Minimum NHS Contribution	£24,950	£12,475	
1	Recovery & Reablement - Community	Reablement Agency Case Worker	Prevention / Early Intervention	Social Prescribing		0	NA		Social Care		NHS			Local Authority	Minimum NHS Contribution	£35,500	£17,750	
2	Recovery & reablement - Residential	Middlesbrough Mobile Therapy Unit (MMRU) - beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		203	90	Number of placements	Social Care		NHS			Private Sector	Minimum NHS Contribution	£615,300	£285,956	
2	Recovery & reablement - Residential	Middlesbrough Mobile Therapy Unit (MMRU) - therapy staffing	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		0	NA	Number of placements	Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	£100,500	£0	Invoices not yet received. Scheme expected to fully spend
3	Recovery & Reablement - Community	Community Reablement Team	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)		456	141	Packages	Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	£963,800	£286,989	Recruitment difficulties
4	Recovery & reablement - Residential	Time To Think Beds to support avoidance of hospital admission	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support admissions avoidance)		36	8	Number of placements	Social Care		LA			Private Sector	Minimum NHS Contribution	£82,100	£24,928	Lower demand during summer months. Expect demand to increase over the winter
5	Recovery & reablement - Rapid Response	Enhanced Rapid Response	Urgent Community Response			0	NA		Community Health		NHS			Private Sector	Minimum NHS Contribution	£81,400	£40,700	
6	Carers	Carer & Engagement Officer	Carers Services	Carer advice and support related to Care Act duties		0	NA	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	£52,200	£26,100	
7	Carers	Support Carers in carrying out their caring role and ensuring carers health and wellbeing	Carers Services	Carer advice and support related to Care Act duties		1800	900	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£205,200	£102,600	
8	Carers	Young Carers Support	Carers Services	Carer advice and support related to Care Act duties		350	175	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£112,500	£84,375	Q3 invoice received early. On track to fully spend
9	Carers	Adult carer Support	Carers Services	Carer advice and support related to Care Act duties		0	NA	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£159,400	£76,695	

10	Carers	Short Breaks	Carers Services	Respite services		103	58	Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£198,700	£80,697	
11	Carers	Support Carers in carrying out their caring role and ensuring carers health and wellbeing	Carers Services	Carer advice and support related to Care Act duties		0	NA	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£173,000	£86,500	
12	Carers	Carers direct payments	Carers Services	Respite services		192	33	Beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution	£127,000	£48,078	
13	Agency Case Workers	Support to Hospital to home discharge and wider prevention agenda	Prevention / Early Intervention	Social Prescribing		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£195,800	£94,824	
14	Connect Falls Service	24/7 emergency response for clients who have a fall at home avoiding the need for	Urgent Community Response			0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£102,900	£51,450	
15	Befriending	Work with people aged 65+ who are experiencing social isolation.	Prevention / Early Intervention	Social Prescribing		0	NA		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£38,600	£38,600	Full contract paid
16	Care at Home Medication Assistance	Medication management of individuals in their own homes	Personalised Care at Home	Physical health/wellbeing			NA		Community Health		NHS			Private Sector	Minimum NHS Contribution	£487,300	£243,650	
17	Assistive Technology Team	Team to prevent/reduce a clients need for support and reduce impact of hospital	Assistive Technologies and Equipment	Digital participation services		0	NA	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	£158,900	£55,768	
18	Hoarding Intervention Scheme	Dedicated case worker to work with clients with compulsive hoarding	Prevention / Early Intervention	Social Prescribing			NA		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£40,000	£10,000	Q2 invoice not yet received
19	Overnight Planned Care	Care and support to individuals in their own homes who have overnight	Home Care or Domiciliary Care	Domiciliary care packages		9828	4914	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£489,800	£259,114	
20	Welfare Rights	Contribution to welfare rights service to provide advice sessions in GP surgeries	Prevention / Early Intervention	Social Prescribing		0	NA		Social Care		NHS			Local Authority	Minimum NHS Contribution	£58,800	£29,400	
21	Medicines Support in the Community	Audit of current medicines processes to offer training & support to Dom Care	Enablers for Integration	Workforce development		0	NA		Social Care		LA			NHS	Minimum NHS Contribution	£56,728	£28,364	
22	Operation Integration - Single Point of Access	Multi disciplinary service hub to provide first point of contact	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	NA		Community Health		NHS			Local Authority	Minimum NHS Contribution	£53,800	£1,287	Invoices not yet received. Scheme expected to fully spend
23	Operation Integration - Single Point of Access	Co-ordinator and call handler to help enable multi disciplinary service hub to	Integrated Care Planning and Navigation	Assessment teams/joint assessment			NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£64,134	£32,067	
24	Operation Integration - Single Point of Access	Social Worker to help enable multi disciplinary service hub to provide first point of	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	NA		Community Health		NHS			Local Authority	Minimum NHS Contribution	£49,200	£24,600	
25	Operational Integration - VCS Liaison	Supporting & Networking with voluntary and community services	Enablers for Integration	Programme management		0	NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£62,000	£31,000	
26	Operational Integration - Project & financial	Project & financial management to BCF	Enablers for Integration	Programme management		0	NA		Social Care		NHS			Local Authority	Minimum NHS Contribution	£149,700	£103,689	
27	Support to Care Homes - Urgent Response &	Emergency health care practioner support - prevent urgent /	Urgent Community Response				NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£218,577	£109,289	
28	Support to Care Homes - Medicine Management	Pharmacy Technicians offering expertise to care homes	Prevention / Early Intervention	Risk Stratification	Other		NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£66,164	£33,082	
29	Support to Care Homes - Nutrition Training & Support	Nutrition and targeted dietician support to care homes	Prevention / Early Intervention	Risk Stratification		0	NA		Community Health		NHS			Local Authority	Minimum NHS Contribution	£122,700	£61,350	
30	Support to Care Homes - End of Life Training &	Secondment of Macmillan CNS to provide palliative and end of life education to care	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	NA		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£32,225	£16,018	
31	Support to Care Homes - Infection Control	Employment of infection prevention and control nurse to provide training to staff in	Prevention / Early Intervention	Risk Stratification		0	NA		Continuing Care		NHS			NHS Community Provider	Minimum NHS Contribution	£33,141	£16,473	
32	Support to Care Homes - Occupational	OT prevention support in care homes re: postural management / Falls offering	Prevention / Early Intervention	Risk Stratification		0	NA		Community Health		NHS			Local Authority	Minimum NHS Contribution	£242,800	£69,075	
33	Support to Care Homes - Healthcall, remote	Android / web based application that allows care homes to send electronic	Integrated Care Planning and Navigation	Care navigation and planning		0	NA		Community Health		NHS			NHS	Minimum NHS Contribution	£44,000	£19,250	
34	Support to Care Homes - Tees Valley Digital Care	Digital Support service to Care homes	Enablers for Integration	System IT Interoperability		0	NA		Community Health		NHS			NHS	Minimum NHS Contribution	£61,563	£30,782	
36	Effective Discharge - Trusted Assessors / Medical Model	Trusted Assessor to facilitate patient discharge to care homes	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	NA		Social Care		NHS			Local Authority	Minimum NHS Contribution	£248,000	£116,680	
37	Effective Discharge - Discharge to Assess	Additional 2 occupational therapists to support discharges from acute	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Social Care		NHS			Local Authority	Minimum NHS Contribution	£56,100	£25,469	

38	Frailty Clinical Intervention Team	South Tees NHS FT - team to co-ordinate care for patients with frailty score of 4 or more	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£275,000	£137,500	
39	Effective Discharge - Hospital Social Work Team	To enable 7 day working and facilitate 7 day hospital discharges	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)		0	NA		Social Care		NHS			Local Authority	Additional LA Contribution	£83,833	£24,369	
39	Effective Discharge - Hospital Social Work Team	To enable 7 day working and facilitate 7 day hospital discharges	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)		0	NA		Social Care		NHS			Local Authority	Minimum NHS Contribution	£182,967	£63,234	
40	Effective Discharge - South Tees Home First Service	Bridging Service from acute care to community and social care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	NA		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£250,000	£125,000	
41	Effective Discharge - Transfer of Care Hub	Expansion of an integrated transfer of care hub to support discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£127,500	£63,750	
42	Emergency Performance & Acute Provider	To support current acute activity	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity		0	NA		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£1,792,663	£896,332	
43	Urgent Care & Hospital Admission Avoidance - A&E	A&E front of House 3 Consultants in A&E	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£149,750	£74,875	
44	Urgent Care & Hospital Admission Avoidance -	Therapies AAU	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£181,517	£90,759	
45	Urgent Care & Hospital Admission Avoidance - AAU 7	AAU 7 day staffing & Medical Decision Maker FOH	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)			NA		Acute		LA			NHS Acute Provider	Minimum NHS Contribution	£304,038	£152,019	
46	Care Act Provision	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Maintaining social care		NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£608,000	£304,000	
46	Care Act Provision	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Independent Mental Health Advocacy			NA		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£27,000	£13,500	
47	Disabled Facilities Grant	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		200	95	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£1,676,657	£697,057	
47	Disabled Facilities Grant	DFG Related Schemes	DFG Related Schemes	Discretionary use of DFG		276	138	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£503,000	£152,571	
47	Disabled Facilities Grant	DFG Related Schemes	DFG Related Schemes	Handyperson services		2000	917	Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	£294,300	£182,608	
48	IBCF Residential placements	IBCF Residential placements	Residential Placements	Care home		77	39	Number of beds	Social Care		LA			Private Sector	iBCF	£3,276,762	£1,638,381	
48	IBCF Home Care / Domiciliary Care	IBCF Home Care / Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		183144	91572	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£4,044,157	£2,022,079	
48	IBCF Personalised Budgets	IBCF Personalised Budgets	Personalised Budgeting and Commissioning				NA		Social Care		LA			Local Authority	iBCF	£1,017,046	£508,523	
48	IBCF Enablers for Integration	IBCF Enablers for Integration	Enablers for Integration	Integrated models of provision			NA		Social Care		LA			Local Authority	iBCF	£293,427	£146,714	
48	IBCF Additional CSDPa equipment	IBCF Additional CSDPa equipment	Assistive Technologies and Equipment	Community based equipment		62	31	Number of beneficiaries	Social Care		LA			Local Authority	iBCF	£14,478	£7,239	
49	Social Care Transfer	Overall Support of Social Care	Home Care or Domiciliary Care	Domiciliary care packages		45864	22932	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£1,012,900	£506,450	
49	Social Care Transfer	Overall Support of Social Care	Personalised Budgeting and Commissioning				NA		Social Care		LA			Private Sector	Minimum NHS Contribution	£624,600	£312,300	
49	Social Care Transfer	Overall Support of Social Care	Residential Placements	Supported housing		20	10	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£830,300	£415,150	
49	Social Care Transfer	Overall Support of Social Care	Residential Placements	Learning disability		5	3	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£566,600	£283,300	
49	Social Care Transfer	Overall Support of Social Care	Residential Placements	Extra care		2	1	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£98,700	£49,350	
49	Social Care Transfer	Overall Support of Social Care	Residential Placements	Care home		37	19	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£1,571,800	£785,900	
49	Social Care Transfer	Overall Support of Social Care	Residential Placements	Nursing home		8	4	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£344,800	£172,400	
51	Effective Discharge - D2A Pathways	To facilitate streamlined D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		425	213	Number of placements	Continuing Care		LA			Private Sector	Local Authority Discharge	£845,934	£491,362	

51	Effective Discharge - D2A Pathways	To facilitate streamlined D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		119	64	Number of placements	Continuing Care		LA			Private Sector	ICB Discharge Funding	£253,393	£147,184	
52	Effective Discharge - D2A Pathways	To facilitate streamlined D2A Pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		23359	12291	Hours of care (Unless short-term in which case it is packages)	Continuing Care		LA			Private Sector	ICB Discharge Funding	£630,700	£265,482	
53	Tees Community Equipment Service expansion	Additional resources to support increased capacity for same-day discharge	Assistive Technologies and Equipment	Community based equipment		169	249	Number of beneficiaries	Social Care		NHS			Local Authority	ICB Discharge Funding	£89,500	£44,750	
55	Hospital Discharge Domiciliary Care Round	Recruit additional capacity to support discharge from hospital	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		12838	4159	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Local Authority Discharge	£277,300	£138,650	
2	Recovery & reablement - Residential	Middlesbrough Mobile Therapy Unit (MMRU) - beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		119	61	Number of placements	Social Care		NHS			Private Sector	Local Authority Discharge	£369,300	£184,121	
3	Recovery & Reablement - Community	Community Reablement Team expansion	Home-based intermediate care services	Reablement at home (to support discharge)		186	40	Packages	Social Care		NHS			Local Authority	Local Authority Discharge	£429,219	£195,587	
3	Recovery & Reablement - Community	Community Reablement Team expansion	Home-based intermediate care services	Reablement at home (to support discharge)		186	30	Packages	Social Care		NHS			Local Authority	ICB Discharge Funding	£316,666	£140,496	
57	Reablement Discharge Co-ordinator	Appointment of Discharge Co-ordinator post to support the flow of discharge from	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	NA		Social Care		LA			Local Authority	Local Authority Discharge	£58,071	£29,000	
59	Admin Support	2% top-slice for admin costs associated with distributing & reporting on Discharge Fund	Other				NA		Social Care		LA			Local Authority	Local Authority Discharge	£40,405	£40,405	
59	Home Group Tees Valley Mental Health Hospital	Team offers housing and social support to patients following discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Acute		NHS			Charity / Voluntary Sector	ICB Discharge Funding	£69,255	£34,628	
60	Complex Discharges Co-ordination	Complex Hospital Discharge Facilitator (band 7) to attend Hospital wards within North	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			NA		Community Health		NHS			NHS Community Provider	ICB Discharge Funding	£16,335	£8,168	
61	In-Reach Assessment & Support for	Band 7 to increase assessment & planning capacity improve flow of	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	NA		Community Health		NHS			NHS Acute Provider	ICB Discharge Funding	£25,950	£12,975	
62	Ambulance Discharge costs	Funding to support patient transport for discharges	Other			0	NA		Other		NHS			NHS	ICB Discharge Funding	£155,000	£77,500	
47	Disabled Facilities Grant	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants	0	62	31	Number of adaptations funded/people supported	Social Care		LA	0.0%		Private Sector	Additional LA Contribution	£522,391	£217,180	
37	Effective Discharge - Discharge to Assess	Additional 2 occupational therapists to support discharges from acute	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£46,500	£21,111	
39	Effective Discharge - Hospital Social Work Team	To enable 7 day working and facilitate 7 day hospital discharges	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)	0	0	NA		Social Care		NHS	0.0%		Local Authority	Additional LA Contribution	£17,800	£17,800	
63	Domiciliary Care Medication Support Interface	Safe management of medication for patients in receipt of domicilary care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	0	0	NA		Community Health		NHS	0.0%		NHS Acute Provider	Additional LA Contribution	£53,167	£26,584	
64	South Tees Integrated Therapy Triage	Singel point of access and triage for all therapy referrals across health and social care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Acute		NHS	0.0%		NHS Acute Provider	Additional LA Contribution	£73,444	£36,722	
65	PCN & Hospital at Home Support	Piot to test if social work support to PCN/Hospital at home would improve	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	NA		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£112,500	£0	delayed recruitment
2	Recovery & reablement - Residential	Middlesbrough Mobile Therapy Unit (MMRU) - beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users	0	95	0	Number of placements	Social Care		LA	0.0%		Private Sector	Additional LA Contribution	£202,719	£0	additional capacity will be utilised over the winter

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Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)
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Better Care Fund 2024-25 Q2 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

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

Data needs inputting in the cell
Pre-populated cells

Note on viewing the sheets optimally

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

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

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

Checklist (2. Cover)

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

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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met,an outline of the challenge and mitigating actions to support recovery should be outlined. it is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- Not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.
Activity
'For reporting across 24/25 we are asking HWB's to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.
For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions
Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs particularly for winter and ongoing data issues.
5.2 C&D H1 Actual Activity
Please provide actual activity figures for April - September 24, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.
Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.
The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.
Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.
Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.
Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Useful Links and Resources

Planning requirements
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

Policy Framework
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework

Addendum
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements

Better Care Exchange
https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome

Data pack
https://future.nhs.uk/bettercareexchange/view?objectId=116035109

Metrics dashboard
https://future.nhs.uk/bettercareexchange/view?objectId=51608880

Better Care Fund 2024-25 Q2 Reporting Template

2. Cover

Version 3.6

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist
Health and Wellbeing Board:	Redcar and Cleveland	Complete:
Completed by:	Kathryn Warnock	Yes
E-mail:	kathryn.warnock@nhs.net	Yes
Contact number:	07766554805	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	No
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D H1 Actual Activity	Yes
6. Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

Better Care Fund 2024-25 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Redcar and Cleveland

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		Yes
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		Yes

Confirmation of Nation Conditions

National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2024-25 Q2 Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Redcar and Cleveland

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning Q1	Q2	Q3	Q4	For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs *Please:* *- describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans* ***- ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan***	Achievements - including where BCF funding is supporting improvements. *Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics*	Variance from plan *Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan*	Mitigation for recovery *Please ensure that this section is completed where a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan*	Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	200.0	158.0	188.4	151.6	240.3	Not on track to meet target	Q1 saw a higher than expected regional rate of admissions, but early Q2 data shows an improvement. The challenges are our demographics which are well recognised. We don't have any support needs at this stage.	Our BCF funded admission avoidance and prevention schemes, such as our support to care home schemes, continue to contribute to reduce unplanned admissions, alongside wider initiatives such as UCR and hospital at home.	We will review this after we receive Q2 data, but STHFT and NTHFT are currently still submitting Same Day Emergency Care (SDEC) activity to Inpatients. However, the removal of this activity to ECDS was reflected in our Avoidable Admissions and Falls plans	We are only slightly over target so feel that the initiatives we have in place will help us achieve the target year end We will continue to collectively monitor performance throughout the year through review of BI information and at regular meetings.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.4%	92.4%	92.5%	92.5%	91.23%	On track to meet target	Although slightly under target for Q1 we hope this will improve in Q2. We have not identified any particular challenges or support needs and are confident in our joined up processes to facilitate discharges.	We have numerous schemes and initiatives in place to support this metric including our Transfer of Care Hub, Home First Service and increased reablement capacity.	Our ongoing implementation of discharge to assess could potentially mean fewer people are discharged straight from hospital to 'home' but maximises their potential to return home after the assessment period.	Not required	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,580.7	308.0	On track to meet target	Performance is better than expected.	We continually aim to reduce emergency admissions due to falls through our BCF funded initiatives such as assistive techology and support to care homes and through the joint plans being developed around falls prevention. We have a South Tees falls prevention strategy in place with a clear action plan to make preventing falls 'everyone's business' and we have a 'Steady on Your Feet' self-assessment on line tool.	N/A	Not required	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	712				not applicable	Not on track to meet target	Although a lower rate than in comparison to previous years, we are currently above target due in part to higher numbers of adults being discharged from hospital on Pathway 2 converting from D2A funded placements to long term care and also due to the Local Authority demographics. No support needs are currently identified.	The Transfer of Care Hub processes continue to sustain improved hospital discharge flow and focus on a home first pathway 1 discharge wherever possible. We are increasing our investment in reablement and independence teams and infrastructure to ensure we are better equipped to support people discharged from a period of hospital stay to return to their preferred place of residence. Our increased BCF spend on Unpaid Carer Support will also increase the offer to carers to reduce carer breakdown and premature admission to residential care facilities.	The probable reasons for the variance from plan are outlined in the challenges section. We currently only have Q1 data so will review again when the latest information is available.	We hope our ongoing initiatives and focus on pathway 1 discharges with reablement wherever possible will bring us back on target. Care home and home care capacity remains good.	Yes

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Redcar and Cleveland

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.	
Estimates for capacity and demand are as predicted. There is fluctuation in demand but this is within anticipated levels. Increased capacity and efficiency in our Home First Service has enabled more referrals to be taken for reablement at home. We are seeking some dedicated BI support to help with capacity and demand planning.	Yes
2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?	
We have a weekly operational meeting with colleagues from the acute hospitals, ICB, NECS and neighbouring Local Authorities. This responds to any challenges in terms of demand and capacity and manages winter surge activity. Strategically we have the South Tees Strategic Oversight Group which will support with escalation as required. Our multi-agency Transfer of Care Hub continues to support with safe, appropriate and timely discharges from hospital which helps to free up capacity and BCF and Discharge Fund investment in reablement services supports with discharges and admission avoidance. We continue to fund a Discharge to Assess period for patients in pathways 1 and 2 from the Discharge Funding available until March 2025.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
None identified currently.	Yes
4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
Our commissioning model allows for flexibility to support periods of peak demand	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6 months of the year
- modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Redcar and Cleveland

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through only spot purchasing (doesn't apply to time to service)					
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	41	42	41	41	40	41	78	71	65	87	81	75	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	2.6	2.6	2.6	2.6	2.6	2.6	2.1	2	1.7	1.7	5.9	1.6						
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	0	0	0	0	0	0						
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	21	21	20	21	20	21	24	20	18	19	18	18	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	3.2	3.2	3.2	3.2	3.2	3.2	1.6	2	1.6	1.7	2	2.3						
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	19	19	19	20	19	19	28	13	16	19	9	17	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	5	5	5	5	5	5	2.5	2.9	2	1.7	3.6	5.1						
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	5	5	5	6	5	5	1	1	2	1	4	2	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	6.5	6.5	6.5	6.5	6.5	6.5	1	1	1	1	1	1						

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:					
Service Area	**Metric**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**
Social support (including VCS)	Monthly activity. Number of new clients.	10	10	10	10	10	10	10	10	10	10	10	10
Urgent Community Response	Monthly activity. Number of new clients.	548	602	643	590	610	600	540	534	527	589	593	547
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	5	5	5	5	4	5	10	10	10	10	10	10
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	6	6	6	6	6	6	5	4	6	5	5	6
Other short-term social care	Monthly activity. Number of new clients.	120	120	120	120	120	120	120	120	120	120	120	120

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Yes
Yes
Yes
Yes
Yes

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Redcar and Cleveland

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£1,952,698	£558,836	28.62%	£1,393,862
Minimum NHS Contribution	£14,491,426	£7,162,405	49.43%	£7,329,021
iBCF	£6,927,994	£3,463,997	50.00%	£3,463,997
Additional LA Contribution	£1,694,502	£867,500	51.19%	£827,002
Additional NHS Contribution	£0	£0		£0
Local Authority Discharge Funding	£1,618,823	£728,751	45.02%	£890,072
ICB Discharge Funding	£1,247,473	£577,426	46.29%	£670,047
Total	**£27,932,916**	**£13,358,915**	**47.82%**	**£14,574,001**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25 Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,130,284	£2,606,394	£1,523,890
Adult Social Care services spend from the minimum ICB allocations	£8,621,497	£5,098,004	£3,523,493

Checklist	Column complete:	Yes	Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
1	Recovery and Reablement - Social Care CCG	Community Reablement & Independence Team	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		1612	806	Packages	Social Care		NHS			Local Authority	Minimum NHS Contribution	£1,117,750	£558,875	
1	Recovery and Reablement - Community Health	Community Reablement & Independence Team	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		162	81	Packages	Social Care		NHS			Local Authority	Minimum NHS Contribution	£112,150	£56,075	
1	Recovery and Reablement - Additional Rapid	Community Reablement & Independence Team	Urgent Community Response			0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£147,950	£73,975	
1	Recovery and Reablement	Community Reablement & Independence Team	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		878	439	Packages	Social Care		NHS			Local Authority	iBCF	£578,600	£289,300	
2	Supported Living	Supported Living Schemes	Housing Related Schemes			0	0		Social Care		NHS			Private Sector	Minimum NHS Contribution	£25,653	£9,916	
3	Intermediate Care Centre	Intermediate Care Centre - a 40 bed facility.	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		357	179	Number of placements	Social Care		NHS			Local Authority	Minimum NHS Contribution	£1,766,600	£883,300	
3	Intermediate Care Centre - Therapists	Therapists providing reablement at the Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		357	179	Number of placements	Social Care		NHS			NHS Acute Provider	Minimum NHS Contribution	£332,000	£166,000	
3	IC Medical Cover	GP medical cover for patients at the Intermediate Care Centre	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		357	179	Number of placements	Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	£5,273	£2,637	
4	Carers Support Service	Identification, advice and support	Carers Services	Carer advice and support related to Care Act duties		1649	825	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£233,200	£86,530	
5	Young Carer Support	Support to young carers	Carers Services	Carer advice and support related to Care Act duties		849	424	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£56,250	£28,125	
6	Hospital Based Carer Support	Information and support in hospitals	Carers Services	Carer advice and support related to Care Act duties		178	89	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£38,800	£16,161	
7	Digital Explorers	To support adults age 55+ to expand their knowledge and confidence in using digital	Assistive Technologies and Equipment	Digital participation services		184	92	Number of beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£30,000	£12,500	
8	Befriending	Age UK - befriending service for older people in their own home	Prevention / Early Intervention	Social Prescribing		0	0		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£45,492	£11,150	
9	MIND reablement - mental health recovery	Mental Health service for older people	Prevention / Early Intervention	Other	Other mental health/wellbeing	0	0		Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£28,815	£6,250	

10	Welfare Rights - advice service in GP surgeries	Contribution to welfare rights service to provide advices sessions in GP surgeries	Prevention / Early Intervention	Social Prescribing		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£61,400	£30,700	
11	Overnight Planned Care Service	Specific service for clients in own home requiring dom care during the night -	Home Care or Domiciliary Care	Domiciliary care packages		12000	6000	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£282,957	£141,475	
12	Care Act Provision	Care Act Implementation Duties	Care Act Implementation Related Duties	Other	Maintaining Social Care		NA		Social Care		LA			Local Authority	Minimum NHS Contribution	£587,575	£293,800	
13	Urgent Care Admissions and Avoidance - 3	3 consultants at A&E	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£143,735	£71,868	
14	Urgent Care Admissions and Avoidance -	Therapies AAU	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£174,256	£87,128	
15	Urgent Care Admissions and Avoidance - 7 day	7 Day Staffing/Medical Decision Maker	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£296,494	£148,247	
16	Emergency Performance at Acute Provider	To support current acute activity	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£1,733,441	£866,721	
17	Disabled Facilities Grants	Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		207	63	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£1,952,698	£558,836	Delays due to reduced staff capacity
17	Disabled Facilities Grants	Adaptations	DFG Related Schemes	Handyperson services		2377	1189	Number of adaptations funded/people supported	Social Care		LA			Local Authority	iBCF	£198,450	£99,225	
18	Integration and Practice Standards team	Team who design and aid implentation of intergration	Enablers for Integration	Integrated models of provision			NA		Social Care		LA			Local Authority	iBCF	£110,550	£55,275	
19	Residential Care	Residential Placements	Residential Placements	Care home		34	17	Number of beds	Social Care		LA			Private Sector	iBCF	£1,377,750	£688,875	
19	Residential Care	Residential Placements	Residential Placements	Care home		53	27	Number of beds	Social Care		LA			Private Sector	Minimum NHS Contribution	£2,247,252	£1,123,611	
20	Home Care	Ensuring people receive the necessary care provision to enable them to remain in	Home Care or Domiciliary Care	Domiciliary care packages		165000	82500	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£3,357,894	£1,678,947	
20	Home Care	Ensuring people receive the necessary care provision to enable them to remain in	Home Care or Domiciliary Care	Domiciliary care packages		82000	41000	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£1,773,135	£886,568	
21	Direct Payments	Personalised budgeting re. care plans and packages	Personalised Budgeting and Commissioning				NA		Social Care		LA			Private Sector	iBCF	£1,100,800	£550,400	
21	Direct Payments	Personalised budgeting re. care plans and packages	Personalised Budgeting and Commissioning				NA		Social Care		LA			Private Sector	Minimum NHS Contribution	£761,732	£380,866	
22	CHESS urgent response and training - support	Urgent response arrangement for care homes re. medical emergencies etc	Urgent Community Response			0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£215,202	£107,601	
23	Medicines Management	Pharmacy techs doing care home audits improving the way care homes handle	Prevention / Early Intervention	Risk Stratification	Preventing admissions to acute setting	0	0		Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	£63,781	£31,891	
24	Nutrition Team	Nutrition and hydration training and support to care homes across South Tees	Prevention / Early Intervention	Risk Stratification		0	0		Community Health		NHS			Local Authority	Minimum NHS Contribution	£117,759	£100,110	
25	End of Life	CCG SPC nurse developing training and support to care homes	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£31,282	£15,641	
26	Infection Control	CCG Infection Prevention Control Nurse training to care homes	Prevention / Early Intervention	Risk Stratification		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£32,144	£16,072	
27	Trusted Assessor Lead	Trusted Assessor to supervise and lead the Trusted Assessor Team	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£50,150	£22,721	
27	Trusted Assessor - Care Homes	Trusted Assessor to facilitate patient discharge to care homes	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£52,800	£23,274	
27	Trusted Assessor - Intermediate Care Centre	Trusted Assessor to facilitate patient discharge to care homes	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£50,950	£0	No one in post currently
27	Trusted Assessor - Mental Health	Trusted Assessor to facilitate patient discharge re mental health patients	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£48,250	£21,612	
28	Single Point of Access	Multi disciplinary service hub to provide first point of contact	Integrated Care Planning and Navigation	Assessment teams/joint assessment			NA		Community Health		NHS			Local Authority	Minimum NHS Contribution	£55,260	£15,142	
28	Single Point of Access - Social Worker	Social Worker to help enable multi disciplinary service hub to provide first point of	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£51,650	£25,825	

28	Single Point of Access - Coordinator & Call	Co-ordinator and call handler to help enable multi disciplinary service hub to	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£60,333	£30,167	
29	BCF Project Management	To manage and administer the BCF programme	Enablers for Integration	Programme management		0	0		Social Care		NHS			Local Authority	Minimum NHS Contribution	£123,551	£115,500	
30	Seven Day Working Hospital Social Work Team	To enable 7 day working and facilitate 7 day hospital discharges	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)		0	0		Social Care		LA			Local Authority	Minimum NHS Contribution	£194,850	£97,425	
31	DTOC Officer	Officer dealing with the avoidance of delayed transfers of care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Acute		NHS			Local Authority	Minimum NHS Contribution	£58,850	£26,630	
32	OT Postural Management	OT staffing to facilitate, advise and support in respect of postural management in care	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		NHS			Local Authority	Minimum NHS Contribution	£58,883	£29,425	
33	Health Call - remote clinical monitoring in care	Remote clinical monitoring system for care homes	Integrated Care Planning and Navigation	Care navigation and planning		0	0		Community Health		NHS			NHS	Minimum NHS Contribution	£44,000	£22,000	
34	EDT Frailty Team - 7 day service	Frailty team for Emergency Department to reduce admissions of frail patients	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£275,000	£137,500	
35	Falls Training	OT training for care home staff on falls prevention and management	Prevention / Early Intervention	Risk Stratification			NA		Community Health		LA			Local Authority	Minimum NHS Contribution	£46,230	£24,867	
36	Transfer of Care Hub	Strategic System Lead and 4 Care Co-ordinators to expand an intergrated transfer of	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			NHS Acute Provider	Minimum NHS Contribution	£127,500	£63,750	
37	South Tees Home First Service	A Home First community based service to ensure that patients are discharged home	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£250,000	£125,000	
38	Meds Support in the Community	To support home care providers with effective training and support to	Prevention / Early Intervention	Risk Stratification	Preventing admissions to acute setting	0	0		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£47,198	£23,599	
39	Deprivation of Liberty Best Interest	Contribution to the costs of DOLS BIA assessments and legal fees	Care Act Implementation Related Duties	Safeguarding			NA		Social Care		LA			Local Authority	iBCF	£203,950	£101,975	
40	Tees Valley Digital Care Home Support	To provide IT digital support to care homes re. NHS mail, Microsoft Teams etc	Enablers for Integration	System IT Interoperability		0	0		Social Care		NHS			NHS Community Provider	Minimum NHS Contribution	£58,765	£29,383	
41	Discharge to Access Occupational	OT staff to assess and facilitate discharges from care homes within a 4 week period	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	0		Community Health		LA			Local Authority	Minimum NHS Contribution	£100,350	£51,089	
42	Risk Share	Continuation of D2A funded schemes	Other		Discharge to assess remains a potential risk to	0	0		Community Health		NHS			NHS	Minimum NHS Contribution	£148,167	£397	
43	Effective Discharge -D2A Pathways	To facilitate streamlined D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		128	64	Number of placements	Continuing Care		NHS			Private Sector	Local Authority Discharge	£1,229,478	£614,739	
45	Care Home Seating & Postural Care Support	Specialist Chairs for Care Homes	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		LA			Private Sector	Additional LA Contribution	£25,000	£16,372	
46	VCS Supporting Discharge	VCS Service working alongside the Transfer Of Care Hub to ensure that the	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Community Health		LA			Charity / Voluntary Sector	Additional LA Contribution	£100,000	£39,333	
47	Animal Assisted Therapy	Visits to individuals in their homes with trained therapy dogs	Personalised Care at Home	Mental health /wellbeing		0	0		Community Health		LA			Private Sector	Additional LA Contribution	£10,000	£0	Discontinued. Funding no longer required
52	Risk Share	Continuation of D2A funded schemes	Other		Discharge to assess remains a potential risk to	0	0		Community Health		NHS			NHS	Additional LA Contribution	£447,279	£400,544	
53	Effective Discharge -D2A Pathways	To facilitate streamlined D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		13	6	Number of placements	Continuing Care		NHS			Private Sector	ICB Discharge Funding	£131,057	£65,528	
54	Reablement - overtime payments	To fund overtime payments to Reablement Staff	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		24	12	Packages	Social Care		LA			Local Authority	ICB Discharge Funding	£15,532	£7,766	
55	Social Care Flow Lead	Officer to facilitate proactive co-ordination of social care flow	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Social Care		LA			Local Authority	ICB Discharge Funding	£48,500	£29,547	
56	Interim Travel payments	Interim Travel Payments to Domiciliary care users	Workforce recruitment and retention				NA	WTE's gained	Social Care		LA			Private Sector	ICB Discharge Funding	£44,976	£22,488	
58	Tees Community Equipment Services	Additional resources to support increased discharge requirements	Assistive Technologies and Equipment	Community based equipment		348	230	Number of beneficiaries	Community Health		NHS			Local Authority	ICB Discharge Funding	£77,321	£38,661	
59	Complex Discharge Co-ordinator	Officer for early identification of complex hospital discharges	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			NHS Acute Provider	ICB Discharge Funding	£13,943	£6,972	
60	In reach assessment & support for	A dedicated in-reach nurse at Teesside Hospice	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes		0	0		Community Health		NHS			NHS Community Provider	ICB Discharge Funding	£25,950	£12,975	

61	Ambulance Discharge Costs	Funding to support patient transport for discharges	Other			0	0		Other		NHS			NHS	ICB Discharge Funding	£124,000	£62,000	
62	Enhanced Reablement & Independence	Increasing Capacity in Reablement & Rapid Response	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		562	281	Packages	Social Care		LA			Local Authority	Local Authority Discharge	£389,345	£114,012	
68	Therapies Team - Intermediate Care Centre	Employment of an additional therapist to enhance the capacity of the existing	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		56	28	Number of placements	Social Care		LA			Local Authority	ICB Discharge Funding	£50,470	£23,639	
70	Home Group Tees Valley Mental Health Hospital	Team offers housing and social support to patients following discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	0		Acute		NHS			Charity / Voluntary Sector	ICB Discharge Funding	£64,125	£32,063	
71	South Tees Domiciliary Care Medication	Two pharmacy technicians posts to support and facilitate medicines pathways.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health		NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£53,167	£26,584	
72	South Tees - Intergrated Therapy Triage -	Two intergrated therapist posts for centralised triage team.	Integrated Care Planning and Navigation	Assessment teams/joint assessment	0	0	0		Community Health		NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£73,444	£36,722	
17	Disabled Facilities Grants	Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants	0	71	35	Number of adaptations funded/people supported	Social Care		LA	0.0%		Private Sector	Additional LA Contribution	£668,826	£334,413	
63	Enhanced Resource to Improve Pathway	An additional team manager within the Transfer of Care Hub and a D2A Lead Co-	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Acute		LA	0.0%		Local Authority	ICB Discharge Funding	£130,600	£63,371	
73	2 Brokerage Officers	Increasing capacity within the Brokerage team will enable officers to directly reduce the	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	ICB Discharge Funding	£72,299	£35,501	
74	Data Analyst	Data Intergration to support commissioning	Enablers for Integration	Joint commissioning infrastructure	0	0	0		Social Care		LA	0.0%		Local Authority	ICB Discharge Funding	£48,700	£22,263	
75	Digitalisation of telecare	Ensuring switch over from analogue to digital services	Assistive Technologies and Equipment	Digital participation services	0	1500	750	Number of beneficiaries	Community Health		LA	0.0%		Local Authority	ICB Discharge Funding	£100,000	£50,000	
76	Overtime for front line care staff.	Overtime for front line care staff to facilitate timely discharge arrangements and	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	ICB Discharge Funding	£300,000	£104,652	
77	Commissioning Officer VCS Supporting	VCS Service working alongside the Transfer Of Care Hub to ensure that the	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Community Health		LA	0.0%		Local Authority	Additional LA Contribution	£46,332	£16,158	
78	Carers Cost of Living Fund	Grants to unpaid carers	Carers Services	Other	Grants to assist - food vouchers/white	50	25	Beneficiaries	Social Care		LA	0.0%		Charity / Voluntary Sector	Additional LA Contribution	£20,000	£10,000	
79	Carers Together - counselling and psychotherapy	Counselling and psychotherapy service for carers experiencing emotional	Carers Services	Other	Counselling and psychotherapy service for carers	75	38	Beneficiaries	Social Care		LA	0.0%		Charity / Voluntary Sector	Additional LA Contribution	£18,200	£18,200	Scheme complete
80	Best Interest Assessor	The Assessor will liaise with ward staff, linking into TOC Hub to support complex	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£48,819	£0	There has been a delay in starting this scheme but it will go ahead
81	Meadowgate Intermediate Care Centre - Culture	Learning programme for all staff delivered through MGI and the Mindset, Language	High Impact Change Model for Managing Transfer of Care	Other	Learning programme for all staff delivered	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£22,500	£0	There has been a delay in starting this scheme but it will go ahead
82	Community Reablement Service - Access	Implementation of the Access CM system will improve the pathway 1 discharge interface	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity	0	0	0		Social Care		LA	0.0%		Private Sector	Additional LA Contribution	£43,400	£0	There has been a delay in starting this scheme but it will go ahead
83	Ask SARA	The initiative will promote adults' independence, by using a self-assessment tool	Assistive Technologies and Equipment	Other	Assistive Technologies and Equipment	1320	660	Number of beneficiaries	Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£20,750	£0	There has been a delay in starting this scheme but it will go ahead
84	Enhanced OT Assessment Clinic - Meadowgate	We propose to further maximise the current offer, with assistive technology and	High Impact Change Model for Managing Transfer of Care	Other	We propose to further maximise the current offer,	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£20,000	£0	There has been a delay in starting this scheme but it will go ahead
85	SCO Post supporting discharge from	The additional post will work to support a reduction in delayed transfer of care and	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£41,000	£0	There has been a delay in starting this scheme but it will go ahead
86	Digital Solutions to Support Unpaid Carers	The procurement of digitally-compatible telecare equipment with the specific	Assistive Technologies and Equipment	Assistive technologies including telecare	0	400	200	Number of beneficiaries	Community Health		LA	0.0%		Private Sector	Additional LA Contribution	£45,000	£11,250	
87	Sustaining Tenancies, Enabling People	STEP prioritises helping adults access safe and secure accommodation, this support	Housing Related Schemes	0	0	0	0		Social Care		LA	0.0%		Charity / Voluntary Sector	Additional LA Contribution	£72,228	£0	There has been a delay in starting this scheme but it will go ahead
88	Brokerage Officer - Complex Needs	An additional Officer in the service will not only improve performance overall, as well	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge	0	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£35,668	£0	There has been a delay in starting this scheme but it will go ahead
66	Mental Health Support for Homecare Staff	To support home care staff through the programme Mind Matters	Other	0	To support home care staff through the programme	0	0		Social Care		LA	0.0%		Local Authority	Additional LA Contribution	£9,500	£11,875	Slight overspend but scheme now complete

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Adding New Schemes:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)
89	We Care You Care	Website development to give information and guidance for all carers across the South	Carers Services	Carer advice and support related to Care Act duties		100	50	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£21,235	£0
90	Transfer of Care Access Business Support	Administrative support to Hospital Social Work Team based at the Transfer Of Care	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Additional LA Contribution	£25,500	£9,355

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