Live Well South Tees Board

Thursday 27th March, 2025

Please note that this meeting will be held in the Mandela Room, Middlesbrough Town Hall.
at 2.00 pm on
Thursday 27th March, 2025

	Agenda Item	Time
1.	**Welcome and introductions** *Alec Brown, Leader of Redcar and Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	2.00pm
2.	**Apologies for Absence** *Alec Brown, Leader of Redcar and Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	
3.	**Declarations of Interest** *Alec Brown, Leader of Redcar and Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	
4.	**Minutes- Live Well South Tees Board - 16 January 2025** (Pages 3 - 8) *Alec Brown, Leader of Redcar and Cleveland Council* *Chris Cooke, Elected Mayor of Middlesbrough*	
5.	**Tees-Wide Tackling Domestic Abuse Perpetration Strategy 2025-2035** *Tracey Brittain, Policy, Partnerships and Delivery Manager, Office of the Police and Crime Commissioner for Cleveland*	2.15pm

6.	**Better Care Fund (BCF) 2025/26 Planning Approval** (Pages 9 - 64) *Kathryn Warnock, South Tees Integration Programme Manager*	3.00pm
7.	**Director of Public Health Annual Report** (Pages 65 - 98) *Mark Adams, Joint Director of Public Health South Tees*	3.30pm

Date and time of next meeting
17 July 2025 at 2pm

LIVE WELL SOUTH TEES BOARD

A meeting of the Live Well South Tees Board was held on Thursday 16 January 2025.

PRESENT: Councillors B Suthers & J Ryles, P Rice, K Warnock, M Short and D Swainston

APOLOGIES FOR ABSENCE: Councillors L Henman,U Earl, A Brown, P Gavigan, P Storey, L Robson & L Sergeant, P Neal, M Adams, D Gardner, B Kilmurray, J Sampson, E Scollay, A Tahmassebi, M Davis, M Graham, R Harrison, C Cooke - Elected Mayor, C Joynes, L Brown, A Smith, J Tynan, S Rawson, L Grabham, J Todd and L Buckley

24/6 **WELCOME AND INTRODUCTIONS**

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

24/7 **DECLARATIONS OF INTEREST**

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

24/8 **MINUTES- LIVE WELL SOUTH TEES BOARD - 12 SEPTEMBER 2024**

The minutes of the Live Well South Tees Board meeting held on 12 September 2024 were submitted and approved as a correct record.

24/9 **SOUTH TEES HEALTH AND WELLBEING STRATEGY: MISSION LED APPROACH - DISCUSSION PAPER**

The Health Improvement Manager for Public Health South Tees delivered a presentation to the Live Well South Tees Board regarding recommendations for the Mission-led approach to the Health and Wellbeing Strategy.

The Live Well South Tees Board had agreed to a “Mission-led” approach for the development of the Health & Wellbeing Strategy and the Joint Strategic Needs Assessment (JSNA).

Members were advised that the Mission-led approach was about shifting from working in isolated silos, where each agency fixed its own small problems, to collaborating across organisations and with communities, tackling the deeper issues together and creating bigger lasting changes.

Missions were measurable, ambitious and time-bound objectives that had the potential to help enable transformative change.

The Live Well Board were asked to consider the following recommendations and provide comment:

System Leadership

Recommendation 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.

It was advised that 4 System Leaders had been appointed but there were 5 outstanding vacancies.

Recommendation 2

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

- Supportive methodologies for problem-solving and decision making
- Clarity on the role of System Leader, focusing on leadership, insight and learning
- Training and support on building a learning culture, capturing, sharing learning and contributing to the development of the learning framework

Recommendation 3

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

Mission-Level Governance

Recommendation 4

We will develop mission-led 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.

Recommendation 5

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

Engaging Communities and People

Recommendation 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.

Developing our Learning Approach

Recommendation 7

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

Delivery through the Policy Frameworks and Powers

Recommendation 8

We will work with both Council's and partners to embed the ambitions of the Health and Wellbeing Strategy Missions into organisational policy frameworks.

Recommendation 9

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

Following the presentation Board Members discussed the recommendations the following points were raised.

- Duplication, lots of work already being undertaken across Tees for example in children's mental health, would it be possible to link in with this work to avoid duplication
- Narrowing the outcome gap already had a workstream
- Key part is scoping what is already in place
- What does it mean for the system leaders, it is a big ask
- Need to understand existing landscapes and structures
- Could be conflict between system leads and providers

- Recommendations had a negative tone structural issues/barriers – building and improving is what we want
- Assumption that current work is not working – lots of great work going on, need to understand what work is going on and build on it
- A lot of reliance on system leaders
- Should there be a system co-ordinator?
- Information sharing – where will information be held and who would have access to information
- Data sharing agreements would need to be put in place
- Need to understand what is meant by devolved autonomy, we have some governance processes in place
- Could the Poverty Network be across South Tees instead of just in Middlesbrough
- Poverty is a negative word
- Good to get positive lived experiences

AGREED: That the Board concluded that they were not able to endorse the recommendations at this current time and requested that this item be brought back to a future meeting of the Live Well South Tees Board.

24/10 **HEALTH PROTECTION ASSURANCE REPORT**

The Advanced Public Health Practitioner for Public Health South Tees presented the South Tees Health Protection Assurance Report 2023/24 to the Live Well Board.

Members heard that Local Authorities through their Directors of Public Health, required assurance that appropriate arrangements were in place to protect the public's health. The report provided a summary of the assurance functions of the Public Health South Tees Health Assurance Partnership and reviewed performance for the period of 1 April 2023 to 31 March 2024 for the Live Well South Tees Board.

The report considered 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 Advanced Public Health Practitioner highlighted the following to the Live Well Board Members:

Environmental

- **Air Quality** - Middlesbrough and Redcar & Cleveland councils produce annual Air Quality Status Reports for DEFRA, showing compliance with national air quality standards and a steady decline in NO_2 levels primarily caused by road vehicles; both councils promote sustainable transport and low-emission vehicle use, supported by a joint Clean Air Strategy (2024) with defined actions to improve and maintain air quality in the South Tees area**.**

- **Noise** - The Public Protection Service addressed noise complaints and ensured compliance with licensing laws to prevent public nuisance; in 2023-24, Middlesbrough recorded 983 complaints (down from 1203 in 2022-23) with minimal enforcement action (4 abatement notices), while Redcar & Cleveland recorded 629 complaints (slightly down from 634) with limited use of Community Protection Warnings and Notices, primarily related to barking dogs, loud music, and parties.

- **Housing Standards -** Good quality housing was essential for health and well-being, with Middlesbrough and Redcar & Cleveland Councils addressing housing standards through statutory powers, Selective Landlord Licensing (SLL) schemes, and responses to tenant complaints; SLL schemes had identified numerous Category 1 and 2 hazards, prompting remedial actions and enforcement where needed, while broader efforts focused on tackling damp, mould, and energy efficiency, alongside

national legislative changes to improve housing conditions and tenant protections.

- **Houses of Multiple Occupation (HMOs) -** HMOs, often housing vulnerable residents, require licensing for properties with 5+ occupants from multiple households. Middlesbrough had 240 licensed HMOs, and Redcar & Cleveland had 32. Inspections ensure compliance with housing standards, including fire and electrical safety, with enforcement actions taken as needed.

- **Affordable Warmth -** Redcar & Cleveland's "Warm & Well" service and Middlesbrough's South Tees Affordable Warmth Partnership provided advice and access to grants for energy efficiency. Initiatives like LAD2 and HUG schemes had improved over 200 homes, while partnerships like "Stay Safe and Warm" assist residents struggling to heat their homes.

- **Control of Environmental and Foodborne Infections:**
  In 2023-24, Middlesbrough inspected 593 food businesses (75% rated 5) and Redcar & Cleveland inspected 648 (91% rated 5). Regulatory actions included business closures for hygiene breaches. Both councils overseen cosmetic treatment premises to ensure public health compliance, with enforcement taken against unregistered operators.

- **Emergency Preparedness:**
  The Cleveland Emergency Planning Unit handled 16 incidents in 2023-24, with training and exercises to enhance resilience. Multi-agency meetings addressed risks like waste fires and extreme weather, while community resilience initiatives, including a grant scheme, were trialled.

- **Severe Weather:**
  The South Tees Adverse Weather Plan consolidated heat and cold weather strategies, ensuring weather alerts were cascaded to councils, care facilities, schools, and health partners to prepare and protect vulnerable populations during extreme weather events.

- **Excess Winter Deaths:**
  In 2021-22, Middlesbrough recorded 20 excess winter deaths (13% higher for ages 85+), while Redcar & Cleveland had zero (1.6%). Compared to 11% for England. Most deaths resulted from circulatory and respiratory diseases, influenced by factors like temperature, and existing circulatory /respiratory diseases rather than hypothermia.

Communicable Diseases

- Covid-19, Flu and RSV cases were monitored, with efforts made to reduce local admissions to alleviate winter pressures.

- Scarlet fever and Group A strep returned to normal levels in February 2023 after high levels from September 2022, they remained normal throughout 2023-24.

- HIV rates increased in 2023, there was an increase in Middlesbrough to 23 cases (from 7.4 per 100k to 15.1 per 100k). Redcar & Cleveland had a low rate at 4.3 per 100k. HIV testing rates had improved from 2020, with a focus on reducing transmission and late diagnosis.

- A Syphilis outbreak in Teesside impacted heterosexual men and women in the 18-34 age group. Gonorrhoea rates also increased. A Tees wide campaign was deployed to increase condom use amongst the younger age group. High chlamydia detection was recognised as a good thing as it prevented onward transmission.

- TB was linked closely to deprivation and health inequalities and was prevalent in those with alcohol/drug misuse, homelessness, prison, mental illness and asylum seekers. Middlesbrough had the highest rate in the Northeast in 2022 according to the latest data available.

Community Resilience

- Making Every Contact Count trained 506 people in 2023-24 total with a total of 1049 people trained.
- South Tees NHS Foundation Trust embedded Making Every Contact Count into training, campaigns and communications
- Health Protection Assurance workshops in 203-24 were well attended, 88 people attended the Children and Young People workshop and 30 attended the adult's workshop.
- HealthStart – focused on improving physical health in schools

Immunisation

Redcar & Cleveland had always performed better in immunisation uptake rates, there are links with levels of deprivation and issues with vaccine records for non-English children.

- Middlesbrough was below 95% target for all 13 indicators, Redcar & Cleveland was below for 8 of 13 indicators. Atrial was taking place in Middlesbrough and Hartlepool with a wide range of partners – GP, midwifery, registry office, promoting 5 steps to protection, school admissions, nurseries, promoting it's not too late.

- The seasonal uptake was similar to national trends, Redcar & Cleveland was slightly above England, Middlesbrough slightly below for covid and flu

- Older adults' uptake was similar to England with PPV (pneumonia) 71% compared to shingles at 48%

Screening

- One of the most effective public health intervention for protecting against serious illness
- Newborn screening at 97.8% compared to England 99%
- The National Child Measurement Programme indicated growing obesity concerns in Middlesbrough (Reception:30% - Y6:40%) and Redcar & Cleveland (Reception:27% - Y6: 39%) – which leads to implications for NHS.

The Live Well Board thanked the Advanced Public Health Practitioner for Public Health South Tees for attending and providing the update to the Board and noted the content of the report.

24/11 **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) policy framework, planning requirements and confirmation of national minimum funding contributions for 2025/26 were yet to be released.

Indications are that the principles for the 2025/26 BCF Policy Framework would 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

It was advised that the next Pharmaceutical Needs Assessment (PNA) was due to be published in October 2025. The Health and Wellbeing Executive had agreed to delegate

responsibility to the PNA Steering Group and would receive updates by exception when required.

ORDERED: The Live Well South Tees Board note the content of the report.

LiveWell SOUTH TEES

Better Care Fund (BCF) Planning Approval 2025-26

To:	Live Well South Tees Health and Wellbeing Board	**Date:**	March 2025
From:	Kathryn Warnock , South Tees Integration Programme Manager	**Agenda**	Item 6
Purpose of the Item	For the Live Well South Tees Health and Wellbeing Board to be assured that Middlesbrough's and Redcar & Cleveland's Better Care Fund (BCF) Plans meet the conditions of the Better Care Fund planning requirements for 2025-26 and to approve the BCF planning submissions for Middlesbrough and Redcar & Cleveland.		
Summary of Recommendations	That Live Well South Tees Health and Wellbeing Board: • are assured that Middlesbrough's and Redcar & Cleveland's Better Care Fund (BCF) Plans meet the conditions of the Better Care Fund planning requirements for 2025-26 • approve the Better Care Fund planning submissions for Middlesbrough and Redcar and Cleveland • are assured that there is robust management and monitoring of BCF expenditure across South Tees		

1 PURPOSE OF THE REPORT

1.1. To update Live Well South Tees Board members on the Better Care Fund planning requirements for 2025/26, assure members that Middlesbrough and Redcar & Cleveland are meeting the conditions and seek endorsement of BCF plans

2 Better Care Fund Plans 2025-26

2.1 This item will update Live Well South Tees Board members on the Better Care Fund planning objectives, conditions, funding and metrics for 2025/26 and seek formal approval for the submission of plans to the BCF national team.

The plans have been developed by South Tees BCF Implementation and Monitoring Group members and were submitted to our local Better Care Manager for initial review and feedback on 3rd March.

The feedback was positive with only minor points highlighted, mainly around links to performance and NHS operational planning, but there has been limited time to review plans given the tight deadlines set to us nationally.

Members are asked to note therefore that the templates circulated with the papers, which form our planning submission, are the latest working versions as of 19th March 2025. There will be updates on the metrics section of the narrative and planning templates before final submission on 31st March, but no significant changes are planned on other areas.

Changes made since circulation of the papers will be highlighted to the Board during the meeting on 27th March.

3	BCF 2024/5 Quarter 3 Reporting Templates

3.1 The national team required updates in quarter 3 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 14th February 2025 with delegated Health and Wellbeing Board approval.

Members are asked to note submission of these templates which are available on request

4	APPENDICES

4.1 Attached are the templates which form part of the BCF Planning Submissions.

Appendix A - Joint South Tees Narrative for Middlesbrough and Redcar & Cleveland
Appendix B - Middlesbrough BCF Planning Template
Appendix C - Redcar & Cleveland BCF Planning Template
Appendix D - Middlesbrough Capacity and Demand Template
Appendix E - Redcar & Cleveland Capacity and Demand Template

Contact Officer
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Agenda Item -

Better Care Fund Planning 2025-26

Kathryn Warnock
South Tees Integration Programme Manager

Live Well South Tees Board – 27th March 2025

Purpose

For the Live Well South Tees Health and Wellbeing Board to be assured that Middlesbrough's and Redcar & Cleveland's Better Care Fund (BCF) Plans meet the conditions of the Better Care Fund planning requirements for 2025-26

For the Live Well South Tees Health and Wellbeing Board to approve the Better Care Fund planning submissions for Middlesbrough and Redcar and Cleveland

Appendix A - Joint Narrative for Middlesbrough and Redcar & Cleveland
Appendix B - Middlesbrough BCF Planning Template
Appendix C - Redcar & Cleveland BCF Planning Template
Appendix D - Middlesbrough Capacity and Demand Template
Appendix E - Redcar & Cleveland Capacity and Demand Template

Background

- Since 2015, the BCF has been crucial in supporting people to live healthy, independent and dignified lives, through joining up health and care services seamlessly around the person.

- This vision is underpinned by 2 core objectives to:
  - enable people to stay well, safe and independent at home for longer
  - provide people with the right care, at the right place, at the right time.

  It requires integrated care boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under section 75 of the NHS Act (2006).
- This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

BCF Planning Requirements 2025-26

The Better Care Fund (BCF) Policy Framework and Planning Requirements were issued on 30th January 2025. They set out the national objectives, conditions and funding for 2025-26.

The objectives of the BCF this year reflect the government's commitment to reform via a shift from sickness to prevention and from hospital to home:

Objective 1: reform to support the shift from sickness to prevention

Local areas must agree plans that help people remain independent for longer and prevent escalation of health and care needs, including:

- timely, proactive and joined-up support for people with more complex health and care needs
- use of home adaptations and technology
- support for unpaid carers

Objective 2: reform to support people living independently and the shift from hospital to home

Local areas must agree plans that:

- help prevent avoidable hospital admissions
- achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
- reduce the proportion of people who need long-term residential or nursing home care

Four National Conditions

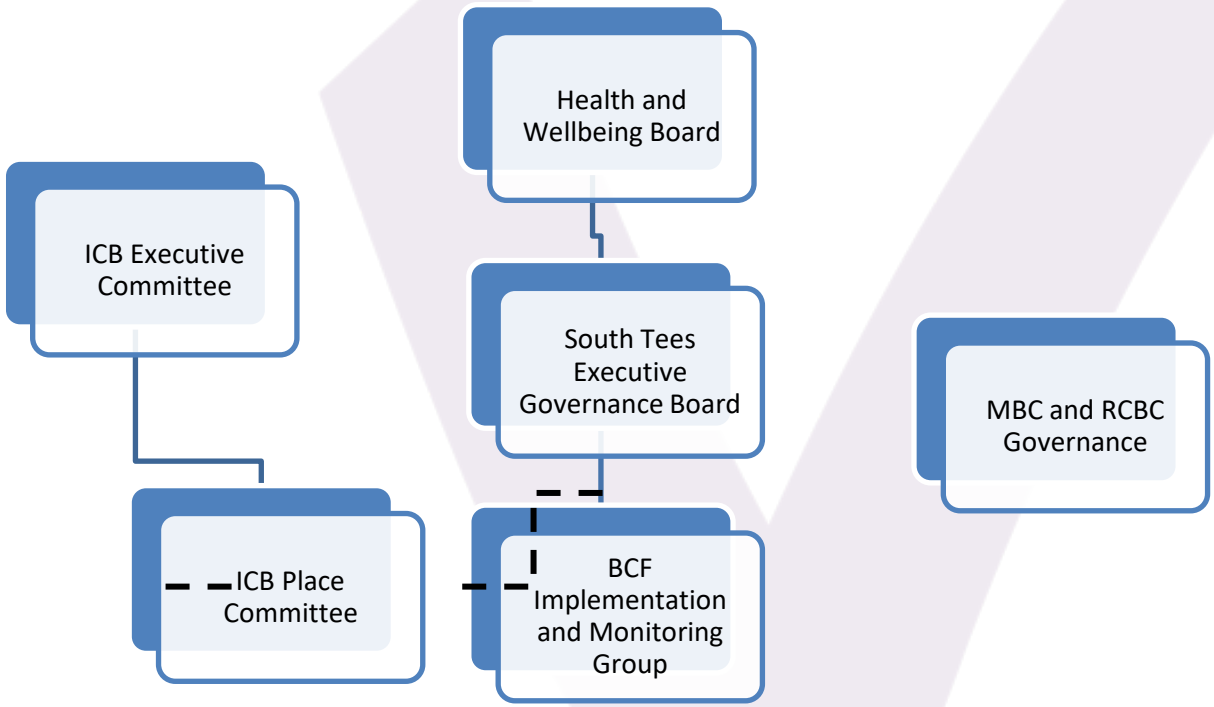
1. Jointly Agreeing a Plan

The ICB and Local Authorities must agree a joint plan, signed off by the HWB, to support the policy objectives of the BCF for 2025 to 2026.

In South Tees:

- We have established governance arrangements in place to agree and manage the BCF programme.
- BCF plans are discussed and jointly agreed between the Local Authority and the ICB to ensure they continue to meet the conditions, requirements, and strategic priorities of the BCF. This includes modifying or decommissioning schemes and consideration of new business case proposals.
- Local Authority and ICB Finance leads work together to monitor expenditure and confirm the funding available to be considered to support transformation and will identify the ways in which this will be provided through recurring or non-recurring funding.

South Tees BCF Governance



Four National Conditions

2. Implementing the objectives of the BCF

HWBs, through their joint plans, should deliver health and social care services that support improved outcomes against the fund's 2 principal objectives

In South Tees we are confident that our BCF schemes and services do support delivery of the objectives through services and initiatives such as our:

Objective 1: reform to support the shift from sickness to prevention

- ✓ Assistive technology and home adaptations
- ✓ Middlesbrough's Staying Put Agency
- ✓ Proactive support to care home schemes

Objective 2: reform to support people living independently and the shift from hospital to home

- ✓ Care coordination through our Integrated Single Point of Access
- ✓ Multi-disciplinary Transfer of Care Hub team who facilitate discharges, home first wherever possible
- ✓ Enhanced reablement services
- ✓ Support to unpaid carers
- ✓ Middlesbrough Mobile Reablement Unit
- ✓ Meadowgate Intermediate Care Centre

Four National Conditions

3. Complying with grant conditions and BCF funding conditions - including maintaining the NHS minimum contribution to adult social care

The NHS minimum contribution to adult social care must be met and maintained by the ICB and will be required to increase by at least 3.9% in each HWB area.

Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and of the Disabled Facilities Grant.

HWB plans will also be subject to a minimum expectation of spending on adult social care, which will be published alongside the BCF planning requirements. HWBs should review spending on social care, funded by the NHS minimum contribution to the BCF, to ensure the minimum expectations are met, in line with the national conditions

We meet this condition in Middlesbrough and Redcar & Cleveland, as illustrated in our BCF planning templates.

Four National Conditions

4. Complying with oversight and support processes

Local areas and HWBs are required to engage with BCF oversight and support processes, which include a regionally led oversight process and an enhanced oversight where there are performance concerns.

In South Tees we:

- ✓ engage regularly with our regional Better Care Manager
- ✓ participate in national webinars and regional events
- ✓ always meet submission deadlines for quarterly returns and plans
- ✓ have had no performance concerns highlighted

Funding Sources

BCF funding is composed of mandatory contributions from integrated care boards and local authorities comprised of:

- Minimum NHS Contributions – which now include the ICB Discharge Funding
- Local Authority Better Care Grant - which now includes the improved Better Care Fund (iBCF) and Local Authority Discharge Funding
- Disabled Facilities Grant
- Local areas can also carry forward underspends. For 2025-26, this is allowing us to maintain existing BCF schemes as the uplifts received are not sufficient to cover increased costs.

Middlesbrough BCF Income 2025-26

Disabled Facilities Grant	**£2,814,373**
NHS Minimum Contribution	**£16,898,602**
Local Authority Better Care Grant	**£10,666,099**
Additional LA contribution	**£300,000**
BCF and DFG Underspend	**£1,116,900**
Total	**£31,795,974**

Redcar & Cleveland BCF Income 2025-26

Disabled Facilities Grant	**£2,221,389**
NHS Minimum Contribution	**£16,077,302**
Local Authority Better Care Grant	**£8,546,817**
BCF and DFG Underspend	**£887,829**
Total	**£27,733,337**

BCF Metrics for 2025-26

For 2025 to 2026 there are 3 headline metrics to help local areas to focus on impact and outcomes that are aligned to the revised objectives of the BCF, the outcomes expected from the BCF, and the government's overall reform vision for neighbourhood health.

The metrics are:

- Emergency admissions to hospital for people aged over 65 per 100,000 population
- Average length of discharge delay for all acute adult patients, derived from a combination of:
  - proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)
  - for those adult patients not discharged on their DRD, average number of days from the DRD to discharge
- Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population

In South Tees we are setting realistic but stretching targets as our aims are to reduce admissions, expedite discharges and avoid long term admissions to care homes through our home first approach. We monitor performance against metrics quarterly.

Recommendations

- Live Well South Tees Health and Wellbeing Board are assured that Middlesbrough's and Redcar & Cleveland's Better Care Fund (BCF) Plans meet the conditions of the Better Care Fund planning requirements for 2025-26

- Live Well South Tees Health and Wellbeing Board approve the Better Care Fund planning submissions for Middlesbrough and Redcar and Cleveland

- Live Well South Tees Health and Wellbeing Board are assured that there is robust management and monitoring of BCF expenditure across South Tees

Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

South Tees Joint BCF Narrative Plan

Live Well South Tees Health and Wellbeing Board

Middlesbrough Council
Redcar & Cleveland Council
North East and North Cumbria Integrated Care Board
South Tees Partner Organisations

LiveWell SOUTH TEES

Section 1: Overview of BCF Plan

Priorities for 2025/26:

Our priorities for this year are in line with the national objectives of supporting people to live healthier independent lives in the community.

Middlesbrough and Redcar & Cleveland and the North East and North Cumbria in general, have a high level of deprivation and health is generally worse than the England average for health outcomes.

Our ICP plan and our South Tees Health and Wellbeing Strategy illustrate our challenges and aims to address these – please see section 3 and the summary below:

Empower the citizens of South Tees to live longer and healthier lives		
Start Well	Live Well	Age 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	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.	More people lead safe, independent lives We want more people leading independent lives through integrated and sustainable support.

Working collectively with our partner organisations, our priorities and plans support the improvement of flow in urgent and emergency care services and developing intermediate care and other short-term care which meets demand:

This year we will:

- Continue to develop our Integrated Single Point of Access which has brought together an integrated co-located team of professionals from each of our partner organisations to create a multi-disciplinary team where professionals needing to access health and/or social care services or seek advice on ongoing care can refer. This supports effective discharge from hospital, helps to prevent unnecessary hospital admissions and to keep an individual safe and independent at home for as long as possible

- Maintain our Transfer of Care Hub based in our acute hospital which is staffed with Trust and Local Authority colleagues who work together to achieve the best timely discharges into the community. Our BCFs jointly fund a Transfer of Care Strategic System Lead post and additional co-ordinator posts. These colleagues represent both health and social care and support existing teams to focus on safe early discharge (to normal place of residence wherever possible), out of hospital assessment, improving patient outcomes and home-based rehabilitation

- Establish a multi-agency discharge hub in our mental health hospital to help ensure safe and effective discharges for our complex patients, replicating some of the learning from developing our acute Transfer of Care Hub

- Continue to reduce the use of community beds and maximise the use of health and social care reablement and rehabilitation services so we can support people to remain in the community and be discharged home from hospital with optimum chance of recovery

- Develop processes to support Hospital at Home services

- Maintain our in-house Frailty Intervention Team who work front of house to avoid admissions to hospital. A focused aim of the team has been to adopt a home first approach to assessment. Initiating assessment at the earliest point allows the team and patient to work in partnership to ensure they facilitate home as the first option

- Continue funding for a discharge to assess period to maximise recovery potential before decisions are made on ongoing care needs

- Continue our flexible Mobile Rehabilitation Unit model in Middlesbrough (MMRU). This provides residential rehabilitation as a step down for those leaving hospital and as a step up for those in the community to avoid hospital admission. It offers time and support to help people regain independence to enable them to return back to the community

- Maintain and promote Meadowgate Intermediate Care Centre for Redcar & Cleveland residents. The residential service is designed to prevent hospital admission and enable timely discharge from acute settings. It provides a structured programme of therapy-led, supportive and enabling care to individuals to assist and enable the person to achieve and maintain an optimum level of health and mobility, with a focus on promoting independence and returning home

Key Changes Since Previous Plan:

We believe that our BCF funded schemes and services already support the objectives as we review schemes annually to be assured that they are performing as expected and contribute to the BCF outcomes. We review scheme delivery to ensure we have good value for money and challenge as needed and only consider new proposals that meet the criteria.

Much of our Better Care Fund is committed recurrently to support living and ageing well through our schemes to support admission avoidance, reablement and home first following a stay in hospital.

Due to the financial uplifts for 2025/26 we are not currently in a position to implement new BCF proposals which we were considering, but we are able to maintain the majority of those we already have in place.

One new initiative we are able to fund, which is about to start, is a joint Rehabilitation Co-ordinator post. This will be to support decisions for the right people being transferred to our

intermediate care bedded settings, with all the necessary support in place to have a seamless, smooth transfer of care into a rehabilitation bed. The role ultimately supports and aims to reduce the risks associated with readmission as the right people go to rehabilitation at the right time. The above post will be supported by all agencies in the system to undertake this role effectively and illustrates our collective focus and priorities.

As a South Tees system, we are increasing our focus on proactive care to improve health and wellbeing for our population.

There have been two small pilots which are helping to inform a future model of care that could be delivered via neighbourhood working.

- A targeted proactive care pilot focusing on emergency department users has been running since late 2024 with some good initial outcomes which will not only inform a model of care but also could be scaled up to serve a larger cohort. This pilot has worked specifically well with our Integrated Single Point of Access MDT forum.
- There has also been a successful pilot led by an advanced clinical practitioner targeting one specific PCN working with care home residents, supporting them with their frailty and helping to reduce unplanned emergency admissions.

The newly formed integrated neighbourhood working group are working with system leaders to develop a plan of action to build a model of care for frailty considering all partner organisation involvement and engagement with a view to develop a robust, sustainable proactive care model that can not only identify, but also treat, monitor and manage the frailty population of South Tees. This would contribute towards the aim of slowing frailty trajectories which in turn reduce overall health and social care burden, avoiding unplanned hospital admissions, expediting the discharge of frail people who have been admitted to hospital as well as preventing any readmissions where possible.

This is supported by Primary Care Networks (PCNs) making significant advances in recruiting to their multi-disciplinary teams [MDT] through the Additional Role Reimbursement Scheme [ARRS], which has 19 roles available to PCNs to employ/ engage. Often PCNs do so by working with community services, VCSE, GP Federations and Acute Trusts to make best use of the resource available. Having a range of roles working together as an MDT is a key as the teams often work together to provide holistic care to enable the best outcomes for their patients.

Examples of integrated working include:

- Enhanced Health in Care Homes working across care homes, primary, community and mental health services to provide proactive care to residents
- Mental health hubs and the mental health practitioners embedded in PCNs
- Community nursing identified to work with defined PCN populations

PCNs have also identified priority areas using population health management data healthy weight, frailty and wound management in our localities.

Approach to Joint Planning & Governance:

We have planned and managed our BCF plans collectively in South Tees since they were first created. This involves regular joint operational and strategic meetings between Middlesbrough Council, Redcar & Cleveland Council and North East and North Cumbria Integrated Care Board commissioners, Pooled Fund managers and BCF leads.

Decisions on BCF funding allocations, metrics and priorities are agreed jointly between the ICB and both Local Authorities. This approach has meant we have been able to develop South Tees wide posts and schemes covering both Local Authority areas. This supports equity and consistency in services and helps promote integration.

BCF leads link in with colleagues across the system including both our acute and mental health Trusts, housing and VCS organisations to develop and consider new proposals which would help to support the BCF objectives and metrics and our system priorities.

If we have any queries or need some guidance, we contact our regional Better Care Manager, refer to the Better Care Exchange and we have a representative on the Local Systems Group.

Our governance arrangements:

- Our BCF Implementation and Monitoring Group (IMG) is formed of commissioning and finance leads from Middlesbrough Council, Redcar & Cleveland Council and North East and North Cumbria ICB and the South Tees Integration Programme Manager and Co-ordinator who are both jointly funded system posts. The group meets monthly to collectively plan, review new proposals and existing schemes, monitor performance against BCF metrics and manage expenditure of the Better Care Funds.

- The South Tees Executive Governance Board (STEGB) acts as the Pooled Budget Partnership Board for our BCFs. The Board receives recommendations from the BCF IMG about new schemes and expenditure, maintains a strategic overview and makes the final decision on how funding should be spent. This is a system partners Director level meeting. Members will ensure plans are considered through each partner organisations' governance arrangements as needed and are in line with national and local priorities.

- The STEGB is now part of the ICB's South Tees Place Committee. The Place Committee has the opportunity to review and provide strategic oversight of our BCF plans. This is a multiagency meeting with representatives from both acute provider Trusts, Housing Associations, GP practices, Voluntary Development Agencies and Healthwatch as well as both Local Authorities and the ICB Director of Place.

- Plans are taken to the Joint Live Well South Tees Board (Health and Wellbeing Board for Middlesbrough and Redcar & Cleveland) for consideration and formal endorsement, after approval from our Local Authority and ICB Chief Executives.

Section 2: National Condition 2: Implementing the objectives of the BCF

Our joint South Tees Health and Care Integration Strategy and work programme fully supports the objectives of the BCF of supporting the shift from sickness to prevention and supporting people to live independently, with a focus on shifting from hospital to home.

The strategy has been developed collectively taking into account local system pressures, how pathways could be improved and learning from best practice, particularly around transfers of care.

The presentation below was endorsed by the South Tees Place Committee in December. It includes achievements to date and we are now developing a detailed work programme to support our objectives.

South Tees Health and Care Integratior

Sickness to Prevention

As outlined above we have an increased system focus on proactive care to support those people with complex health and care needs.

A key aspect of Redcar & Cleveland's programme of development through BCF Funding has been to increase efficiency and capacity within the health and social care system and promote prevention and independence through digital development. This includes:

- ✓ BCF funding to expand the Telecare assistive technology service. Two new 'assistive tech' champions have been recruited to support with the referral, triage and ongoing case management of residents with short- and long-term social care needs that can be managed with assistive technology. These workers have been employed to ensure the correct, most cost-effective and efficient assistive tech is utilised to support vulnerable adults and reduce the reliance on longer-term, more restrictive forms of care. Falls technology utilised through the Telecare Service significantly reduces the requirement for ambulance calls and admission to acute settings. This service is something we will continue to develop throughout 25/26.
- ✓ Telecare equipment to be installed within our Reablement setting (Meadowgate) to further promote the use of technology in the step-down pathway.
- ✓ Utilised BCF funding to launch a digital support tool called AskSARA, which can be used independently by local residents to source ideas, tips and equipment to help maintain their independence at home.

Middlesbrough's programme of BCF funded provisions are tailored to support to individuals based on their specific needs. By focusing on prevention, early intervention, and community-based support, we ensure that all individuals have the opportunity to live healthy, independent lives, regardless of their circumstances.

Through providing innovative technology solutions, community engagement activities, emergency monitoring and response, and therapeutic support, services empower individuals to manage their health and remain independent. This holistic approach ensures that everyone receives the necessary care and support to live safely and comfortably in their own homes.
https://www.middlesbrough.gov.uk/adult-social-care/middlesbrough-independent-living-services/

Middlesbrough's Independent Living Services include:

a) The Staying Put Agency which offers:

- ✓ The Handyperson service offering minor repairs to make homes safer
- ✓ Major adaptations using the Disabled Facilities Grant
- ✓ Staying Included service which supports people to live independently at home and stay connected to their community.

b) Assistive Technology

Our dedicated Assistive Technology Assessor's work closely with Health & Social Care and the community. Supporting residents of Middlesbrough, they carry out holistic assessments providing essential equipment within the resident's home to enable them to remain safe and independent which supports in the reduction of hospital admissions. Working closely with our Hospital Social Work team and A & E therapies, they support with discharge planning and follow up once a resident has returned home from A & E

From April 24 to the end of August 24 the Assistive Technology Team has supported 243 services users to stay living independently in their own home. These referrals were for things such as Assistive Technology / Telecare services, Connect monitor and response service, Key safes, grab rails and referrals to Case workers within the Staying Put Agency as well as other support services within Middlesbrough council.

c) Connect Falls Service

Connect supports service users to live safely and independently whilst giving family members and carers extra reassurance that their loved ones have someone to contact if help, or assistance is needed.

The service works by installing a piece of equipment in the customer's home, this allows them to alert the Contact Centre Customer Advisors who will identify what help or support is needed for the service user. They will assess each user's individual and immediate needs, offer support and advice, and decide on any further action that needs to be taken to mitigate any risk

From April 2024 to the end of August 2024 Connect Response staff have responded to 1059 calls from service users who required support. Of the 1059 responses 727 had fallen at home. With the equipment in place and the support of the trained response staff only 94 of these service users required an ambulance call out, and only 47 needed further medical attention, which meant 680 of our service users remained safe at home after their fall.

d) Hospital to Home (H2H) Service

Our H2H service facilitates safe and timely discharges from hospital to home. The service ensures that individuals have the necessary support and equipment in place to return home safely after a hospital stay. This reduces the risk of readmission and promotes recovery in a familiar environment.

The service supported 110 patients to be discharged home safely from April 2024 to the end of August 2024, providing assessments and necessary equipment to ensure a smooth transition.

UCR and Hospital@Home

Although not currently funded from the Better Care fund, our Urgent Community Response and Hospital@Home services play a vital role in supporting the BCF outcomes:

Collaborative working across both health and care systems has supported and strengthened our Urgent Community Response (UCR). Our UCR services provide an urgent response within 2 hours with a reablement care response within two-days. In South Tees we provide a person-centred approach to optimise independence and confidence, enable recovery and prevent a decline in functional ability. We have promoted and adopted through new ways of working through a 'no wrong door' ethos through an integrated Single Point of Access (ISPA) working flexibly based on need, not diagnosis/condition.

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

- ✓ reduces the risk of deconditioning, delirium and hospital-acquired infection
- ✓ improves hospital flow
- ✓ supports older people to regain independence
- ✓ reduces demand for readmission and long-term support.

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

Hospital@Home Services support sub-optimised patients to be discharged home from hospital earlier or for patients in crisis at home in the community to be monitored virtually by a Senior Clinician led multi-disciplined team. This service is coordinated through the South Tees Care Coordination Hub, wrapping the necessary health and care services, equipment and digital monitoring technologies around the patient, to enable early discharge with a Home First approach and to deliver care closer to home in avoiding unnecessary conveyances to hospital. South Tees Hospital @ Home Services provide 70 Virtual Beds split 40/30 between Respiratory and Frail / elderly patients. South Tees continue to work collaboratively with North Tees to expand their Hospital@Home offer to include more conditions being cared for virtually in the community.

Hospital to Home:

As well as the services outlined above, our plans include these continuing services and initiatives which help to prevent avoidable admissions, support timely discharges and recovery and independence in people's own homes:

- ✓ Additional funding for our Tees Community Equipment Service which supports more timely discharges with the appropriate equipment
- ✓ Our wide-ranging support offer for unpaid carers including the enhancement of our financial support to unpaid Carers and Young Carers through the utilisation of hospital discharge grants and increased funding for young carer support groups.
- ✓ Introduction of a digital rota system and Digital Social Care Records within Redcar & Cleveland's Reablement Service to support personalised care and outcome planning and maximise efficient use of time within the reablement team. This innovation will increase capacity within the reablement team to meet the needs of more adults and support more early supported discharges and free up capacity in hospital. We also plan to increase the number of reablement workers within the team in the early months of 2025/26, to increase reablement caseload capacity. We envisage that this will reduce pressures on the Home First service and ensure more residents discharged from hospital are given the opportunity of a reablement pathway.
- ✓ Middlesbrough's Reablement Service also uses an electronic care management system. This means that visits can be allocated and re-allocated throughout the day to suit the person's needs. The system allows the OT's and the Case Managers to read updates from Reablement Officer's in 'real-time', so the service is effective and responsive. It also allows Reablement Officers access to risk assessments, which helps keep people safe. The Reablement Service has started to use the electronic care management system to develop a suite of reporting tools. Firmly embedded within the service is the use of Assistive Technology which further supports independence. The Reablement service is also expanding which will enable the service to increase caseload capacity, which will support hospital discharges
- ✓ Occupational therapy support to Care Homes – utilising funding to invest in postural support systems and support for residential care providers to enable them to better manage people discharged from hospital under pathway 2 to reduce the chances of further deterioration and to support with successful discharge home, particularly those under temporary D2A.
- ✓ Continuation of our broad support to care home schemes to avoid unnecessary admissions which includes training on medicines optimisation, nutrition, infection control and end of life care and our Care Home Emergency Rapid Response Service
- ✓ Redcar & Cleveland's Sustaining Tenancies, Enabling People (STEP) service funded from the BCF to provide intensive, specialist support for people with complex learning difficulties and mental health diagnoses to maintain secure tenancy in the community. This scheme has the potential to reduce delayed transfers of care by providing services for adults to be supported in a community setting rather than a hospital placement once they are ready for discharge. STEP also helps to reduce non-elective admissions by supporting eligible residents through a crisis, providing support and reablement in their home environment.

Outside of direct BCF funding, Redcar & Cleveland have also recently commissioned a new domiciliary care framework. Following significant consultation with stakeholders, changes have been made to the allocation of a package of care on the new framework, moving from a quality ranking to a geographically based allocation. Allocating new packages of care to the provider currently delivering the closest existing package of care, should support a reduction in travel time, travel costs, potentially develop more efficient runs for care workers, support the sustainability of providers and care workers. This development has the potential to significantly reduce waiting times for domiciliary care support, reducing delays in hospital discharge and supporting home-first models of care.

In addition, due to the popularity of extra care schemes in the borough we are working with a local housing and care provider to develop a new 83-unit extra care facility in Guisborough, which, again, will support home-first models of care, and potentially reduce the reliance on 24hr residential care as an alternative to domiciliary care provision.

Metrics Ambitions Support Alignment to System Partner Plans/Capacity & Demand:
Section to be updated

Emergency Admissions:
For the draft submission, we have adopted a 2% proxy for demographic growth and a do nothing approach for 2025/26 to arrive at the numbers included on Emergency Admissions on our planning templates. This is to allow more time for detailed planning, discussions with Acute Trust and other colleagues and quantifying the expected impact of UCR, Virtual Ward and other admission avoidance schemes. There will be revised figures, ambitions and rationale in our final submission.

Discharge Delays:
For the draft submission, we have just maintained the 2024/25 position and assumed no change in numerator or denominator in the figures entered on our planning templates. As above this is to allow more time for detailed planning, discussions with colleagues and assessment of the impact of our schemes which support effective discharges. There will be revised figures, ambitions and rationale in our final submission.

Residential Admissions:
The section will be completed on the final submission.

Home First Approach:

Our Home First approach and strategy has been in place for several years and led to the creation of our multiagency Transfer of Care Hub to drive a home first approach wherever possible and to use short term bedded care only when necessary.

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

Through our BCFs, we contribute to our Acute Trust's Home First Service which provides a bridging service from acute to community and social care. This expedites discharges out of hospital for patients on pathway 1 back to their own home. The service helps to reduce lengths of stay in hospital, preventing hospital associated deconditioning, and supports the patient at home until they are either able to function without support or social care commences.

This Home First Service has around 80 referrals a month with these average patient outcomes on conclusion of their service:

- 40% require no ongoing package of care (POC)
- 40% passed to a Care Provider
- 15% receive Reablement support
- 5% admitted to hospital due to a deterioration
- A deep dive in October showed that 31% of those with ongoing support had a smaller package than at point of referral

Our enhanced community reablement services continue to support our home first approach.

Redcar & Cleveland's community reablement service had these outcomes up to November 2024:

- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement has increased from 80.9% in March 2024 to 87.8% in November 2024
- Supported 297 adults to be discharged from hospital into reablement from January to November 2024.
- Supported 100 adults in the prevention of a hospital or care home admission through the Rapid Response service.
- Maintained a dynamic throughput of adults receiving reablement support with the average length of stay on the service at 29 days, helping to support Pathway 1 demand and flow

Middlesbrough's community reablement service has developed over time and now has the capacity for 117 30-minute visits per day, 365 days a year compared to 28 visits it was undertaking in 2018.

The service outcomes from May to October are illustrated below:

CHC Funded Medication Calls Only	6
Continued Existing POC	7
Decreased POC	1
Increased POC	3
New POC	39
Hospital Admission	16
Move to Extra Care Housing	1
No further needs identified	133
Self-Discharge	7
Person seen but did not commence	67
Total	280

Consolidated Discharge Funding:

Following a review of our plans and spending, we have agreed to retain most of our schemes and services previously funded from the Discharge Funding, as we are confident that they contribute to improving flow and outcomes for our residents. We are not therefore planning to make any significant changes in our planned expenditure but will review this in year as we do every year. In accordance with the conditions, the focus of our schemes funded from the Discharge Fund was supporting discharges, but we have other schemes which support UEC flow as outlined above, including prevention services and our in-house frailty team.

Significantly, we are planning to maintain our funded discharge to assess period to try and prevent permanent or long-term admissions to nursing or residential care and facilitate earlier discharges which improves flow out of the hospital. This allows time for the patient to recover before being assessed to access the right care in the right place, ideally returning home whenever possible.

We will ensure that our core bedded intermediate care capacity is used to optimal effect but our focus is to increase the number of pathway 1 discharges with reablement support wherever possible and to reduce the number of patients being discharged on pathway 2. We are continuing funding to increase capacity in our pathway 1 services to support this.

Our model does allow us to spot purchase additional pathway 2 capacity from the general care home market. Demand fluctuates and we have previously been able to use the discharge funding to fund this activity. Whilst our main focus is to reduce the reliance on community beds, particularly spot purchase, and to shift to pathway 1 and 0, our capacity and demand predictions suggest that we will need to maintain this model moving forward. However, given the potential shortfall in funding this year, we will closely monitor spend and activity and may need to review our approach in year.

As can be seen in the information below taken from the new BCF dashboard, we performed better than the England average figures on the discharge metrics, evidencing our improvements in patient flow.

All metrics for Middlesbrough in December 2024

Date	Metric	Value	Regional average	England	Change
December 2024	% of all HWB discharges that are from acceptable trusts	100%	100%	90%	
December 2024	Average days from Discharge Ready Date to date of discharge (exc 0 day delays)	5.6	5.1	6.1	
December 2024	Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	0.47	0.81	0.81	
December 2024	Date of discharge is same as Discharge Ready Date	92%	82%	87%	

All metrics for Redcar and Cleveland in December 2024

Date	Metric	Value	Regional average	England	Change
December 2024	% of all HWB discharges that are from acceptable trusts	100%	100%	90%	
December 2024	Average days from Discharge Ready Date to date of discharge (exc 0 day delays)	6	5.1	6.1	
December 2024	Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	0.65	0.81	0.81	
December 2024	Date of discharge is same as Discharge Ready Date	89%	82%	87%	

Intermediate Care Capacity & Demand:

For the draft submission, we have replicated demand figures used in 2024/25. Capacity figures have been updated to reflect our predicted capacity this year.

The key factors in completion of our capacity and demand template are:

- We have not identified capacity issues in any of the pathways as our models allow for flexibility in managing capacity to react to peaks in demand
- We have included our enhanced reablement capacity which should lead to less reliance on bedded care. The current figures show a combination of Local Authority and Home First Service capacity
- UCR activity is not included in this template but plays a significant role in supporting care in the community as outlined above
- During 2025/26 we plan to develop a local system dashboard which will help us to track and monitor intermediate care activity and outcomes. This will help inform future planning.

Section 3: Local priorities and duties

Promoting Equality & Reducing Inequalities:

Working in partnership, the ICB, local authority partners and other members of the Integrated Care Partnership (ICP), including Healthwatch and the voluntary, community and social enterprise sector, have developed our collective ICP strategy, 'Better Health and Wellbeing for All' which details our integrated care strategy for our region (please see link below). All partners are developing local BCF and other plans, giving due regard to the commitment made within this strategy.

To support this and working with public health colleagues across the region, we created a Healthier and Fairer Group which is a forum with a purpose to tackle the health inequalities across our region. This enables joint planning and focus on some of the biggest health issues for the region

The Healthier and Fairer Programme leads the work on prevention and reducing health and healthcare inequalities across the ICB. Within our local system, we are committed to delivering on our major prevention programmes which include tobacco control, alcohol use and healthy weight and managing obesity and we work with partners to ensure a joined-up approach to tackling key risk factors through primary and secondary prevention.

The health inequalities workstream encompasses delivery against the ICB's statutory duty and the fulfilment of Core20Plus5 requirements and ambitions as set out in the integrated care strategy.

https://northeastnorthcumbria.nhs.uk/icp/better-health-and-wellbeing-for-all/#:~:text=The%20ICP%20includes%2014%20local,improves%20services%2C%20and%20reduces%20inequality.

Our BCF funded prevention and home first schemes continue to support the most vulnerable, often those with long term conditions. We also make a contribution to the Welfare Advice service, which works to ensure people access to what they are entitled.

Schemes which are led by the Local Authority conform to a comprehensive set of report standards that combine with the impact assessment process to ensure that due regard is given not only to the Public Sector Equality Duty but also to wider implications of the decision (such as social, environmental and economic impacts). This enables a full and integrated assessment of the impacts of the decision to be presented to decision-makers and stakeholders.

Engaging or Consulting:

The ICB published its People and Communities Strategy in July 2022, outlining how patients and key stakeholders are involved in key decisions. To underpin this further, a strategic relationship has been formed with Healthwatch across the region. The ICB currently funds the coordination of all 14 Healthwatch organisations across the region who, in turn, support local public engagement and involvement.

The ICB triangulates all feedback and seeks to understand consistent issues arising to inform local or regional action. This is coordinated through the ICB's Patient Voice Group which is also supported by Healthwatch.

Our BCF plans have been developed collectively over the past years through regular operational and strategic meetings between ICB and Local Authority commissioners, Pooled Fund managers and BCF leads. Linking with the members of these groups, colleagues across the system, including Housing and VCS organisations, have the opportunity to present business cases around potential new schemes to address a need or gap identified and which would support the BCF and system priorities and metrics. These are duly considered against what uncommitted funding is available and decisions on whether to approve them are made jointly between the Integrated Care Board (ICB) and Local Authority.

In South Tees many of our recent schemes have been developed to support the Home First/Discharge agenda. This has involved extensive discussions and planning with colleagues in South Tees Hospitals NHS Foundation Trust and more recently with our local mental health trust.

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

Senior representatives from both Local Authorities and the ICB have regular review meetings with the Voluntary Development Agencies, who represent the local VCS organisations, and with Housing providers to talk through the challenges and explore opportunities for joint initiatives. There are also working groups with various organisations such as AGE UK to help develop new schemes and we have a strong local Carers Forum.

Reducing Inequality in Access to NHS Services:

The ICB has funded a programme of work, facilitated through our local authorities, targeting inclusion health groups. This work identifies interventions to increase access to general health care for people with multiple and complex needs (associated with drug, alcohol, homelessness, and mental ill health), in line with place-based approaches already available or prioritised.

Another area of work is 'Waiting Well' which is a regionwide programme that uses a population health management approach to provide targeted support to patients who are waiting for planned surgical procedures.

The NHS Constitution sets out the right for patients to choose the organisation that provides their treatment when they are referred for a first outpatient appointment for a service led by a consultant, subject to certain exceptions. The ICB has arrangements in place to ensure that patients are offered choices.

Supporting and Involving Unpaid Carers:

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

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

Since April 2022 Redcar & Cleveland Borough Council and Middlesbrough Borough Council launched the first jointly commissioned All-age Carer Support Service. The service is funded through BCF and enables the two local authorities and ICB to work collaboratively, and consistently, on our support to unpaid Carers.

Services commissioned as part of the South Tees Carer Support Service is underpinned by the South Tees Carer Strategy and South Tees Carers Forum, both established in 2021. The Forum takes a proactive approach to monitoring the progress of Carer Support across the locality to ensure the aims and objectives of the Strategy are being met year-to-year. deemed not appropriate. The service enables the Carer to access a break from the caring role at times to suit them, creating a more flexible approach to respite

A key focus of the South Tees Carer Support Service is to ensure that new carers are identified swiftly to ensure they are equipped to embark on the caring role. Our Hospital Liaison Service aims to identify carers in hospital settings prior to the cared for person being discharged home. The service can offer support to carers in the discharge process to ensure their voice is heard and to reduce the potential for the cared for person to ‘rebound’ back into hospital or care settings due to the carer being ill-equipped on discharge.

Likewise our Primary Care Support Service aims to increase awareness and identification of Carers in GP settings, so that the caring role, and the impact this may have on the carer, is considered when the cared for person attends GP appointments.

We have a range of carers support schemes funded from our BCFs which are listed in our planning templates.

Live Well South Tees Health and Wellbeing Strategy:

Our Live Well South Tees Health and Wellbeing Strategy and mission led approach supports all the above areas (please see the embedded document below)

HWB Board members are assured that our BCF plans contribute to our objectives.

Health & Wellbeing Strategy 2024-2030.p

Better Care Fund 2025-26 Update Template

1. Guidance

Overview

HWBs will need to submit a narrative plan and a planning template which articulates their goals against the BCF objectives and how they will meet the national conditions in line with the requirements and guidance set out in the table on BCF Planning Requirements (published).

Submissions of plans are due on the 31 March 2025 (noon). Submissions should be made to the national Better Care Fund england.bettercarefundteam@nhs.net and regional Better Care Managers.

This guidance provides a summary of the approach for completing the planning template, further guidance is available on the Better Care Exchange.

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.
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

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
Within the BCF submission guidance there will be guidance to support collaborating across HWB on the completion of templates.

Data Sharing Statement

This section outlines important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at https://data.england.nhs.uk/sudgt/ - Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. This accountability must not be delegated.

Data completeness and data quality:
- 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 in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
- The checker column, which can be found on each individual sheet, 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'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission.

3. Summary

The summary sheet brings together the income and expenditure information, pulling through data from the Income and Expenditure tabs and also the headline metrics into a summary sheet. This sheet is automated and does not require any inputting of data.

4. Income

This sheet should be used to specify all funding contributions to the Health and Wellbeing Boards (HWB) Better Care Fund (BCF) plan and pooled budget for 2025-26. The final planning template will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant and Local Authority Better Care Grant. Please note the Local Authority Better Care Grant was previously referred to as the iBCF. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and LA. You will be able to update the value of any Additional Contributions (LA and NHS) income types locally. If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

5. Expenditure

For more information please see tab 5a Expenditure guidance.

6. Metrics

Some changes have been made to the BCF metrics for 2025-26; further detail about this is available in the Metrics Handbook on the Better Care Exchange. The avoidable admissions, discharge to usual place of residence and falls metrics/indicators remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics/indicators.

For 2025-26 the planning requirements will consist of 3 headline metrics and for the planning template only the 3 headline metrics will be required to have plans entered. HWB areas may wish to also draw on supplementary indicators and there is scope to identify whether HWB areas are using these indiciators in the Metrics tab. The narrative should elaborate on these headline metrics [and may] also take note of the supplementary indicators. The data for headline metrics will be published on a DHSC hosted metrics dashboard but the sources for each are also listed below:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions as well as the projection 65+ population figure on monthly basis
- This will then auto populate the rate per 100,000 population for each month
https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65
Supplementary indicators:
Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
Emergency hospital admissions due to falls in people aged 65+.

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This requires inputting the % of total spells where the discharge was on the discharge ready date and also the average length of delay in days for spells where there was a delay.
- A composite measure will then auto calculate for each month described as 'Average length of discharge delay for all acute adult patients'
- This is a new SUS-based measure where data for this only started being published at an LA level since September hence the large number of missing months but early thinking about this metric is encouraged despite the lack of available data.
https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/
Supplementary indicators:
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Local data on average length of delay by discharge pathway.

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
- This section requires inputting the expected numerator (admissions) of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2024-25. Data for this metric is not yet published, but local authorities will collect and submit this data as part of their SALT returns. You should use this data to populate the estimated data in column H.
- The pre-populated cells use the 23-24 SALT data, but you have an option of using this or local data to use as reference to set your goals.
- The pre-populated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) mid-year population estimates. This is changed from last year to standardize the population figure used.
- The annual rate is then calculated and populated based on the entered information.
https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2023-24
Supplementary indicators:
Hospital discharges to usual place of residence.
Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement.

7. National conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund Policy Framework for 2025-26 (link below) will be met through the delivery of your plan. (Post testing phase: add in link of Policy Framework and Planning requirements)

This sheet sets out the four conditions, where they should be completed and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that the HWB meets expectation. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the four National conditions are as below:

- National condition 1: Plans to be jointly agreed
- National condition 2: Implementing the objectives of the BCF
- National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)
- National condition 4: Complying with oversight and support processes
- How HWB areas should demonstrate this are set out in Planning Requirements

HM Government

NHS England

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. 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 Better Care Exchange) 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 (MHCLG, DHSC, NHS England) 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.

Governance and Sign off

		Complete:
Health and Wellbeing Board:	Middlesbrough	Yes
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes	Yes
If no indicate the reasons for the delay.		Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

Submitted by:	Kathryn Warnock	Yes
Role and organisation:	South Tees Integration Programme Manager	Yes
E-mail:	kathryn.warnock@nhs.net	Yes
Contact number:	07766 554805	Yes
Documents Submitted (please select from drop down) In addition to this template the HWB are submitting the following:	Narrative	Yes
	C&D National Template	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	Chris	Cooke	chris_cooke@middlesbrough.gov.uk		Yes
	Health and Wellbeing Board Chair	Cllr	Alec	Brown	alec.brown@redcar-cleveland.gov.uk		
Named Accountable person	Local Authority Chief Executive		Erik	Scollay	erik_scollay@middlesbrough.gov.uk		Yes
	ICB Chief Executive 1		Sam	Allen	s.allen24@nhs.net	North East and North Cumbria ICB	Yes
	ICB Chief Executive 2 (where required)						
	ICB Chief Executive 3 (where required)						
Finance sign off	LA Section 151 Officer		Andrew	Humble	Andrew_Humble@middlesbrough.gov.uk		Yes
	ICB Finance Director 1		TBC			North East and North Cumbria ICB	Yes
	ICB Finance Director 2 (where required)		TBC				
	ICB Finance Director 3 (where required)						
Area assurance contacts	Local Authority Director of Adult Social Services		Louise	Grabham	louise_grabham@middlesbrough.gov.uk		Yes
	DFG Lead		Suzanne	Hodge	suzanne_hodge@middlesbrough.gov.uk		Yes
	ICB Place Director 1		Martin	Short	martin.short@nhs.net	North East and North Cumbria ICB	Yes
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)						
	ICB Place Director 3 (where required)						

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes		Yes
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes		Yes
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes		Yes
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes		Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes		Yes

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan

At time of this draft, we are waiting for the latest data to inform our metric setting and demand planning. We expect to have this by the final submission.

Yes

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

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Middlesbrough

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,814,373	£2,814,373	£0
NHS Minimum Contribution	£16,898,602	£16,898,602	£0
Local Authority Better Care Grant	£10,666,099	£10,666,099	£0
Additional LA Contribution	£1,416,900	£1,416,900	£0
Additional ICB Contribution	£0	£0	£0
Total	**£31,795,974**	**£31,795,974**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£8,696,026
Planned spend	£8,803,935

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	2,077	2,034	1,943	2,081	1,974	1,777	2,168	2,049	2,534	2,530	2,424	2,522

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.52	0.52	0.39	0.61	0.53	0.36	0.44	0.38	0.46	0.84	0.47	0.51

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	713.3	157.6	157.6	177.3	181.3

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Middlesbrough

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Middlesbrough	£2,814,373
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£2,814,373**

Local Authority Better Care Grant	Contribution
Middlesbrough	£10,666,099
Total Local Authority Better Care Grant	**£10,666,099**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Middlesbrough	£300,000	Match Funding - Carers
Middlesbrough	£866,900	24/25 BCF Underspend
Middlesbrough	£250,000	24/25 DFG Underspend
Total Additional Local Authority Contribution	**£1,416,900**	

NHS Minimum Contribution	Contribution
NHS North East and North Cumbria ICB	£16,898,602
Total NHS Minimum Contribution	**£16,898,602**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£16,898,602**	

	2025-26
Total BCF Pooled Budget	**£31,795,974**

Funding Contributions Comments
Optional for any useful detail

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Middlesbrough

<< Link to summary sheet

Running Balances	2025-26 Income	2025-26 Expenditure	2025-26 Balance
DFG	£2,814,373	£2,814,373	£0
NHS Minimum Contribution	£16,898,602	£16,898,602	£0
Local Authority Better Care Grant	£10,666,099	£10,666,099	£0
Additional LA contribution	£1,416,900	£1,416,900	£0
Additional NHS contribution	£0	£0	£0
Total	**£31,795,974**	**£31,795,974**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	2025-26 Planned Spend	2025-26 Unallocated
Adult Social Care services spend from the NHS minimum allocations	£8,696,026	£8,803,935	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Assistive technologies and equipment	Community Equipment	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 178,300	
1	Assistive technologies and equipment	Telecare Equipment & Support	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 109,000	
1	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Reablement Brokerage	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 25,950	
1	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Reablement Brokerage	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 25,950	
1	Housing related schemes	Reablement Agency Caseworker	2. Home adaptations and tech	Social Care	Local Authority	NHS Minimum Contribution	£ 37,600	
2	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Middlesbrough Mobile Therapy Unit (MMRU) - beds	6. Reducing the need for long term residential care	Acute	Private Sector	NHS Minimum Contribution	£ 666,100	
2	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Middlesbrough Mobile Therapy Unit (MMRU) - beds	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 387,400	
2	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Middlesbrough Mobile Therapy Unit (MMRU) - therapy staffing	6. Reducing the need for long term residential care	Acute	NHS Community Provider	NHS Minimum Contribution	£ 116,300	
3	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Community Reablement Team	4. Preventing unnecessary hospital admissions	Acute	Local Authority	NHS Minimum Contribution	£ 848,475	
3	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Community Reablement Team	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 549,735	
3	Home-based intermediate care (short-term home-based rehabilitation, reablement and	Community Reablement Team	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	Local Authority Better Care Grant	£ 487,290	
4	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Time To Think Beds to support avoidance of hospital admission	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 87,800	
5	Long-term home-based social care services	Overnight Planned Care - care and support to individuals in their own homes who have overnight support needs.	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 497,200	
6	Urgent community response	Enhanced Rapid Response	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 84,600	
7	Support to carers, including unpaid carers	Carer & Engagement Officer	3. Supporting unpaid carers	Social Care	Local Authority	NHS Minimum Contribution	£ 51,400	
8	Support to carers, including unpaid carers	Support Carers in carrying out their caring role and ensuring carers health and wellbeing	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 229,066	
9	Support to carers, including unpaid carers	Young Carers Support	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 115,988	
10	Support to carers, including unpaid carers	Adult carer Support	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 158,146	
11	Support to carers, including unpaid carers	Short Breaks	3. Supporting unpaid carers	Social Care	Private Sector	NHS Minimum Contribution	£ 213,300	
12	Support to carers, including unpaid carers	Support Carers in carrying out their caring role and ensuring carers health and wellbeing	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	Additional LA Contribution	£ 173,000	
13	Support to carers, including unpaid carers	Carers direct payments	3. Supporting unpaid carers	Social Care	Private Sector	Additional LA Contribution	£ 127,000	
14	Wider local support to promote prevention and independence	Staying Included Service - ways to live independently at home and stay connected to the community	6. Reducing the need for long term residential care	Social Care	Local Authority	NHS Minimum Contribution	£ 202,000	
15	Urgent community response	Connect Falls Service - 24/7 emeergency response for clients who have a fall at home	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 106,900	
16	Wider local support to promote prevention and independence	Befriending Service - Work with people aged 65+ who are experiencing social isolation.	6. Reducing the need for long term residential care	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 38,600	
17	Short-term home-based social care (excluding rehabilitation, reablement or recovery services)	Care at Home medication assistance - Medication management of individuals in their own homes	4. Preventing unnecessary hospital admissions	Community Health	Private Sector	NHS Minimum Contribution	£ 506,500	
18	Wider local support to promote prevention and independence	Assistive Technology Team - prevent/reduce a clients need for support and reduce impact of hospital admissions	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 167,400	
19	Wider local support to promote prevention and independence	Hoarding Intervention Service - Dedicated case worker to work with clients with compulsive hoarding disorders	1. Proactive care to those with complex needs	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 40,000	
20	Wider local support to promote prevention and independence	Welfare Rights -Contribution to welfare rights service to provide advice sessions in GP surgeries	1. Proactive care to those with complex needs	Primary Care	Local Authority	NHS Minimum Contribution	£ 61,100	
21	Evaluation and enabling integration	Single Point of Access - multi disciplinary service hub to provide first point of contact	4. Preventing unnecessary hospital admissions	Community Health	Local Authority	NHS Minimum Contribution	£ 99,318	
22	Evaluation and enabling integration	Single Point of Access - Co-ordinator and call handler to help enable multi disciplinary service hub to provide first point of contact	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 67,675	
23	Evaluation and enabling integration	Liaison Worker - Supporting & Networking with voluntary and community services	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 61,400	
24	Evaluation and enabling integration	Project & Financial Management to BCF	5. Timely discharge from hospital	Other	Local Authority	NHS Minimum Contribution	£ 141,800	
25	Evaluation and enabling integration	Social Worker Virtual Ward PCN / Hospital at Home - improve outcomes for clients	4. Preventing unnecessary hospital admissions	Acute	Local Authority	Additional LA Contribution	£ 113,000	
26	Evaluation and enabling integration	South Tees Integrated Therapy Triage - single point of access and triage for all therapy referrals across health & social care	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	Additional LA Contribution	£ 95,000	
27	Urgent community response	CHERRs - Emergency health care practioner support - prevent urgent / emergency/unscheduled and acute episodes of care in elderly patients residing in care homes	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 218,564	
28	Long-term residential/nursing home care	Medicine Management - Pharmacy Technicians offering expertise to care homes	4. Preventing unnecessary hospital admissions	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 69,817	
29	Long-term residential/nursing home care	MUST Service - Nutrition and targeted dietician support to care homes	4. Preventing unnecessary hospital admissions	Community Health	Local Authority	NHS Minimum Contribution	£ 128,650	
30	End of life care	End of Life Training & Support - Secondment of Macmillan CNS to provide palliative and end of life education to care homes	4. Preventing unnecessary hospital admissions	Continuing Care	NHS Community Provider	NHS Minimum Contribution	£ 33,872	
31	Long-term residential/nursing home care	Infection control - Employment of infection prevention and control nurse to provide training to staff in care homes.	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 34,835	
32	Long-term residential/nursing home care	Occuptional Thearpy prevention support in care homes re: postural management / Falls offering training / advice & support	4. Preventing unnecessary hospital admissions	Community Health	Local Authority	NHS Minimum Contribution	£ 218,200	
33	Evaluation and enabling integration	Healthcall, remote clinical monitoring in care homes - Android / web based application that allows care homes to send electronic referral information to the most appropriate	4. Preventing unnecessary hospital admissions	Community Health	NHS	Additional LA Contribution	£ 40,468	
34	Evaluation and enabling integration	Care Homes Connected Digital Service	4. Preventing unnecessary hospital admissions	Community Health	NHS	Additional LA Contribution	£ 63,396	
35	Evaluation and enabling integration	Medicines Support in the Community - Audit of current medicines processes to offer training & support to Dom Care Providers	4. Preventing unnecessary hospital admissions	Social Care	NHS	Additional LA Contribution	£ 59,860	
36	Evaluation and enabling integration	Medicines Optimisation Support to Domiciliary care providers - Safe management of medication for patients in receipt of domicilary care services	4. Preventing unnecessary hospital admissions	Community Health	NHS Acute Provider	Additional LA Contribution	£ 56,102	
37	Discharge support and infrastructure	Discharge to Assess Occupational Therapists - to support discharges from acute settings and provide a link between hospital and the community	5. Timely discharge from hospital	Acute	Local Authority	Additional LA Contribution	£ 106,900	
38	Discharge support and infrastructure	Trusted Assessor to facilitate patient discharge to care homes	5. Timely discharge from hospital	Acute	Local Authority	NHS Minimum Contribution	£ 257,600	
39	Discharge support and infrastructure	Hospital Social Work Team weekend service	5. Timely discharge from hospital	Acute	Local Authority	NHS Minimum Contribution	£ 307,300	
40	Discharge support and infrastructure	South Tees Home First Service - Bridging Service from acute care to community and social care	5. Timely discharge from hospital	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 64,625	
40	Discharge support and infrastructure	South Tees Home First Service - Bridging Service from acute care to community and social care	5. Timely discharge from hospital	Community Health	NHS Acute Provider	Additional LA Contribution	£ 198,156	
41	Discharge support and infrastructure	Transfer of Care Hub - expansion of an integrated transfer of care hub to support discharges	5. Timely discharge from hospital	Acute	NHS Acute Provider	Additional LA Contribution	£ 134,018	
42	Evaluation and enabling integration	Urgent Care & Hospital Admission Avoidance - A&E front of House 3 Consultants in A&E	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 157,406	
43	Evaluation and enabling integration	Urgent Care & Hospital Admission Avoidance - Therapies AAU	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 190,797	
44	Evaluation and enabling integration	Urgent Care & Hospital Admission Avoidance - AAU 7 day staffing & Medical Decision Maker FOH	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 319,581	
45	Wider local support to promote prevention and independence	Frailty Clinical Intervention Team - South Tees NHS FT - team to co-ordinate care for patients with frailty score of 4 or more at James Cook	1. Proactive care to those with complex needs	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 289,059	
46	Evaluation and enabling integration	Emergency Performance & Acute Provider - to support current acute activity	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 1,882,444	
47	Evaluation and enabling integration	Care Act Implementation Related Duties	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 660,000	
48	Long-term home-based social care services	Social Care Transfer	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 1,915,655	
48	Personalised budgeting and commissioning	Social Care Transfer	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 649,153	
48	Long-term residential/nursing home care	Social Care Transfer	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 2,683,392	
49	Evaluation and enabling integration	Care Conference June 2025	1. Proactive care to those with complex needs	Other	Private Sector	NHS Minimum Contribution	£ 3,000	
50	Disabled Facilities Grant related schemes	Disabled Facilities Grant (DFG) - Adaptations	2. Home adaptations and tech	Social Care	Private Sector	DFG	£ 2,814,373	
51	Long-term residential/nursing home care	IBCF Residential placements	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 3,276,762	
51	Long-term home-based social care services	IBCF Home Care / Domiciliary Care	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 4,044,157	
51	Personalised budgeting and commissioning	IBCF Personalised Budgets	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 1,017,046	
51	Evaluation and enabling integration	IBCF Enablers for Integration	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 293,427	
51	Assistive technologies and equipment	IBCF Additional CSDPa equipment	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 14,478	
52	Discharge support and infrastructure	Discharge to Assess - Domiliary Care. To facilitate stramlined D2A pathway	5. Timely discharge from hospital	Acute	Private Sector	NHS Minimum Contribution	£ 562,282	
52	Discharge support and infrastructure	Discharge to Assess - Domiliary Care. To facilitate stramlined D2A pathway	5. Timely discharge from hospital	Acute	Private Sector	Local Authority Better Care Grant	£ 259,200	
53	Discharge support and infrastructure	Discharge to Assess - Bed based intermediate care services. To facilitate stramlined D2A pathway	5. Timely discharge from hospital	Acute	Private Sector	NHS Minimum Contribution	£ 470,666	
53	Discharge support and infrastructure	Discharge to Assess - Bed based intermediate care services. To facilitate stramlined D2A pathway	5. Timely discharge from hospital	Acute	Private Sector	Local Authority Better Care Grant	£ 845,934	
54	Discharge support and infrastructure	Admin Support - 2% top-slice for admin costs associaed with distributing and reporting	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 40,405	
55	Discharge support and infrastructure	TCES Community Equipment Service expansion - Additional resources to support increased capacity for same-day discharge requirements.	5. Timely discharge from hospital	Acute	Local Authority	NHS Minimum Contribution	£ 103,900	
56	End of life care	In-Reach Assessment & Support for EOL/Palliative Care Patients - Band 7 to increase assessment & planning capacity improve flow of patients from ED and inpatient wards	5. Timely discharge from hospital	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 27,277	
57	Discharge support and infrastructure	Ambulance Discharge costs. Funding to support patient transport for discharges	5. Timely discharge from hospital	Other	NHS	NHS Minimum Contribution	£ 162,924	
50	Disabled Facilities Grant related schemes	Disabled Facilities Grant (DFG) - Adaptations	2. Home adaptations and tech	Social Care	Private Sector	Additional LA Contribution	£ 250,000	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS minimum:

- **Area of spend** selected as 'Social Care' and **Source of funding** selected as 'NHS Minimum Contribution'

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	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	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	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.
4	Wider support to promote prevention and independence	Prevention/early intervention	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 wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes 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
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term 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.
7	Long-term home-based social care services	Personalised care at home	Long-term 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 or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	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'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	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.
10	Long-term residential or nursing home care	Residential placements	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.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	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.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, 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. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	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.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Middlesbrough

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Complete:
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	2,049	2,010	1,911	2,049	1,951	1,734	2,148	2,010	n/a	n/a	n/a	n/a	FOR THIS DRAFT SUBMISSION, we have adopted a 2% proxy for demographic growth and a do nothing approach for 2025/26 to arrive at the numbers included. This is to allow more time for detailed planning, discussions with FT and other colleagues and quantifying the expected impact of UCR, Virtual Ward and other admission avoidance schemes. There will be revised figures, ambitions and rationale in our final submission.	Yes
	Number of Admissions 65+	520	510	485	520	495	440	545	510	n/a	n/a	n/a	n/a		
	Population of 65+*	25,374	25,374	25,374	25,374	25,374	25,374	25,374	25,374	n/a	n/a	n/a	n/a		
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
	Rate	2,077	2,034	1,943	2,081	1,974	1,777	2,168	2,049	2,534	2,530	2,424	2,522		
	Number of Admissions 65+	527	516	493	528	501	451	550	520	643	642	615	640		Yes
	Population of 65+	25,374	25,374	25,374	25,374	25,374	25,374	25,374	25,374	25,374	25,374	25,374	25,374		

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.36	0.48	0.38	n/a	n/a	n/a	n/a	FOR THE DRAFT SUBMISSION, we have just maintained the 2024/25 position and assumed no change in numerator or denominator. This is to allow more time for detailed planning, discussions with colleagues and assessment of the impact of our schemes which support effective discharges. There will be revised figures, ambitions and rationale in our final submission.	Yes
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	90.9%	91.3%	91.6%	n/a	n/a	n/a	n/a		
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	4.0	5.5	4.5	n/a	n/a	n/a	n/a		
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
Average length of discharge delay for all acute adult patients	0.52	0.52	0.39	0.61	0.53	0.36	0.44	0.38	0.46	0.84	0.47	0.51		
Proportion of adult patients discharged from acute hospitals on their discharge ready date	89.8%	88.8%	90.6%	88.9%	89.9%	91.4%	91.8%	91.9%	89.6%	87.7%	89.7%	89.9%		Yes
For those adult patients not discharged on DRD, average number of days from DRD to discharge	5.07	4.60	4.12	5.54	5.22	4.17	5.37	4.74	4.46	6.82	4.59	5.09		Yes

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	374.4	756.7	713.3	157.6	157.6	177.3	181.3		We have applied a % decrease to the number of admissions based on 23/24 data. We continue to operate a scheme of delegation which is working effectively and hopefully we will continue to see a reduction in placements. We continue to support independence and home first on discharge remains our priority. With regards to 23/24, our actual was recorded at 155.	Yes
	Number of admissions	95	192	181	40	40	45	46			Yes
	Population of 65+*	25,374	25,374	25,374	25,374	25,374	25,374	25,374			

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes	Yes

HM Government

NHS England

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Middlesbrough

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes			Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

Better Care Fund 2025-26 Update Template

1. Guidance

HM Government

NHS England

Overview

HWBs will need to submit a narrative plan and a planning template which articulates their goals against the BCF objectives and how they will meet the national conditions in line with the requirements and guidance set out in the table on BCF Planning Requirements (published).

Submissions of plans are due on the 31 March 2025 (noon). Submissions should be made to the national Better Care Fund england.bettercarefundteam@nhs.net and regional Better Care Managers.

This guidance provides a summary of the approach for completing the planning template, further guidance is available on the Better Care Exchange.

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.
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

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
Within the BCF submission guidance there will be guidance to support collaborating across HWB on the completion of templates.

Data Sharing Statement

This section outlines important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at https://data.england.nhs.uk/sudgt/ - Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. This accountability must not be delegated.

Data completeness and data quality:
- 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 in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
- The checker column, which can be found on each individual sheet, 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'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission.

3. Summary

The summary sheet brings together the income and expenditure information, pulling through data from the Income and Expenditure tabs and also the headline metrics into a summary sheet. This sheet is automated and does not require any inputting of data.

4. Income

This sheet should be used to specify all funding contributions to the Health and Wellbeing Boards (HWB) Better Care Fund (BCF) plan and pooled budget for 2025-26. The final planning template will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant and Local Authority Better Care Grant. Please note the Local Authority Better Care Grant was previously referred to as the iBCF. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and LA. You will be able to update the value of any Additional Contributions (LA and NHS) income types locally. If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

5. Expenditure

For more information please see tab 5a Expenditure guidance.

6. Metrics

Some changes have been made to the BCF metrics for 2025-26; further detail about this is available in the Metrics Handbook on the Better Care Exchange. The avoidable admissions, discharge to usual place of residence and falls metrics/indicators remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics/indicators.

For 2025-26 the planning requirements will consist of 3 headline metrics and for the planning template only the 3 headline metrics will be required to have plans entered. HWB areas may wish to also draw on supplementary indicators and there is scope to identify whether HWB areas are using these indiciators in the Metrics tab. The narrative should elaborate on these headline metrics [and may] also take note of the supplementary indicators. The data for headline metrics will be published on a DHSC hosted metrics dashboard but the sources for each are also listed below:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions as well as the projection 65+ population figure on monthly basis
- This will then auto populate the rate per 100,000 population for each month
https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65
Supplementary indicators:
Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
Emergency hospital admissions due to falls in people aged 65+.

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This requires inputting the % of total spells where the discharge was on the discharge ready date and also the average length of delay in days for spells where there was a delay.
- A composite measure will then auto calculate for each month described as 'Average length of discharge delay for all acute adult patients'
- This is a new SUS-based measure where data for this only started being published at an LA level since September hence the large number of missing months but early thinking about this metric is encouraged despite the lack of available data.
https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/
Supplementary indicators:
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Local data on average length of delay by discharge pathway.

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
- This section requires inputting the expected numerator (admissions) of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2024-25. Data for this metric is not yet published, but local authorities will collect and submit this data as part of their SALT returns. You should use this data to populate the estimated data in column H.
- The pre-populated cells use the 23-24 SALT data, but you have an option of using this or local data to use as reference to set your goals.
- The pre-populated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) mid-year population estimates. This is changed from last year to standardize the population figure used.
- The annual rate is then calculated and populated based on the entered information.
https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2023-24
Supplementary indicators:
Hospital discharges to usual place of residence.
Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement.

7. National conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund Policy Framework for 2025-26 (link below) will be met through the delivery of your plan. (Post testing phase: add in link of Policy Framework and Planning requirements)

This sheet sets out the four conditions, where they should be completed and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that the HWB meets expectation. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the four National conditions are as below:

- National condition 1: Plans to be jointly agreed
- National condition 2: Implementing the objectives of the BCF
- National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)
- National condition 4: Complying with oversight and support processes
- How HWB areas should demonstrate this are set out in Planning Requirements

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. 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 Better Care Exchange) 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 (MHCLG, DHSC, NHS England) 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.

Governance and Sign off

		Complete:
Health and Wellbeing Board:	Redcar and Cleveland	Yes
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	Yes	Yes
If no indicate the reasons for the delay.		Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

Submitted by:	Kathryn Warnock	Yes
Role and organisation:	South Tees Integration Programme Manager	Yes
E-mail:	kathryn.warnock@nhs.net	Yes
Contact number:	07766 554805	Yes
Documents Submitted (please select from drop down) In addition to this template the HWB are submitting the following:	Narrative	Yes
	C&D National Template	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	Alec	Brown	alec.brown@redcar-cleveland.gov.uk		Yes
	Health and Wellbeing Board Chair	Cllr	Chris	Cooke	chris_cooke@middlesbrough.gov.uk		
Named Accountable person	Local Authority Chief Executive		John	Sampson	john.sampson@redcar-cleveland.gov.uk		Yes
	ICB Chief Executive 1		Sam	Allen	s.allen24@nhs.net	North East and North Cumbria ICB	Yes
	ICB Chief Executive 2 (where required)						
	ICB Chief Executive 3 (where required)						
Finance sign off	LA Section 151 Officer		Phil	Winstanley	philip.winstanley@redcar-cleveland.gov.uk.		Yes
	ICB Finance Director 1		TBC			North East and North Cumbria ICB	Yes
	ICB Finance Director 2 (where required)						
	ICB Finance Director 3 (where required)						
Area assurance contacts	Local Authority Director of Adult Social Services		Patrick	Rice	patrick.rice@redcar-cleveland.gov.uk		Yes
	DFG Lead		Lisa	Gales	lisa.gales@redcar-cleveland.gov.uk		Yes
	ICB Place Director 1		Martin	Short	martin.short@nhs.net	North East and North Cumbria ICB	Yes
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)						
	ICB Place Director 3 (where required)						

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes		Yes
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes		Yes
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes		Yes
	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes		Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes		Yes

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan

time of this draft, we are waiting for the latest data to inform our metric setting and demand planning. We expect to have this by the final submission.

Yes

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

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2025-26 Planning Template

3. Summary

Selected Health and Wellbeing Board: Redcar and Cleveland

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,221,389	£2,221,389	£0
NHS Minimum Contribution	£16,077,302	£16,077,302	£0
Local Authority Better Care Grant	£8,546,817	£8,546,817	£0
Additional LA Contribution	£887,829	£887,829	£0
Additional ICB Contribution	£0	£0	£0
Total	**£27,733,337**	**£27,733,337**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£8,959,900
Planned spend	£10,739,613

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,655	1,740	1,603	1,820	1,628	1,397	1,810	1,710	1,862	1,938	1,713	1,847

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	0.84	0.57	0.62	0.74	0.49	0.61	0.56	0.52	0.63	0.73	0.70	0.47

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	739.4	240.4	146.0	155.2	197.8

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Redcar and Cleveland

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Redcar and Cleveland	£2,221,389
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£2,221,389**

Local Authority Better Care Grant	Contribution
Redcar and Cleveland	£8,546,817
Total Local Authority Better Care Grant	**£8,546,817**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Redcar and Cleveland	£737,829	Projected BCF underspend as at the end of 24/25
Redcar and Cleveland	£150,000	Projected Disabled Facilities Grant Underspend 24/25
Total Additional Local Authority Contribution	**£887,829**	

NHS Minimum Contribution	Contribution
NHS North East and North Cumbria ICB	£16,077,302
Total NHS Minimum Contribution	**£16,077,302**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£16,077,302**	

	2025-26
Total BCF Pooled Budget	**£27,733,337**

Funding Contributions Comments Optional for any useful detail

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Redcar and Cleveland

<< Link to summary sheet

Running Balances	2025-26 Income	2025-26 Expenditure	2025-26 Balance
DFG	£2,221,389	£2,221,389	£0
NHS Minimum Contribution	£16,077,302	£16,077,302	£0
Local Authority Better Care Grant	£8,546,817	£8,546,817	£0
Additional LA contribution	£887,829	£887,829	£0
Additional NHS contribution	£0	£0	£0
Total	**£27,733,337**	**£27,733,337**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	2025-26 Planned Spend	2025-26 Unallocated
Adult Social Care services spend from the NHS minimum allocations	£8,959,900	£10,739,613	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Community Reablement and Independence Team	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 1,184,815	
1	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Community Reablement and Independence Team	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 118,879	
1	Urgent community response	Community Reablement and Independence Team	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 156,827	
1	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Community Reablement and Independence Team	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 412,706	
2	Housing related schemes	Supported Living Schemes	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 25,650	
3	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Bed Based Intermediate Care Services	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 1,872,596	
3	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Bed Based Intermediate Care Services	5. Timely discharge from hospital	Social Care	NHS Acute Provider	NHS Minimum Contribution	£ 351,920	
3	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Bed Based Intermediate Care Services	5. Timely discharge from hospital	Social Care	NHS Community Provider	NHS Minimum Contribution	£ 5,564	
4	Support to carers, including unpaid carers	Identification, advice and support	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 240,429	
5	Support to carers, including unpaid carers	Support to Young Carers	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 57,994	
6	Support to carers, including unpaid carers	Information and Support in Hospitals	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 40,003	
7	Wider local support to promote prevention and independence	Age UK - befriending service for older people in their own home	6. Reducing the need for long term residential care	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 45,500	
8	Wider local support to promote prevention and independence	Mental Health Services for Older People	4. Preventing unnecessary hospital admissions	Mental Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 28,800	
9	Wider local support to promote prevention and independence	Contribution to Welfare Rights Service to provide advice sessions in GP surgeries	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 61,813	
10	Long-term home-based social care services	Overnight Planned Care - overnight domiciliary care service	4. Preventing unnecessary hospital admissions	Social Care	Private Sector	NHS Minimum Contribution	£ 309,830	
11	Evaluation and enabling integration	Care Act Implementation Duties	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 610,693	
12	Evaluation and enabling integration	3 consultants at A & E	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 151,083	
13	Evaluation and enabling integration	Therapies AAU	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 183,165	
14	Evaluation and enabling integration	7 Day Staffing/Medical decision Maker	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 311,652	
15	Evaluation and enabling integration	To Support Current Acute Activity	4. Preventing unnecessary hospital admissions	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 1,820,254	
16	Disabled Facilities Grant related schemes	DFG related schemes	2. Home adaptations and tech	Social Care	Private Sector	DFG	£ 2,221,389	
16	Disabled Facilities Grant related schemes	Handyperson Services	2. Home adaptations and tech	Social Care	Local Authority	Local Authority Better Care Grant	£ 198,450	
17	Evaluation and enabling integration	Team who design and aid implementation of integration	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 110,550	
18	Long-term residential/nursing home care	Residential Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 1,377,750	
18	Long-term residential/nursing home care	Residential Placements	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 2,335,917	
19	Long-term home-based social care services	Ensuring people receive the necessary care provision to remain in their own homes	6. Reducing the need for long term residential care	Social Care	Private Sector	Local Authority Better Care Grant	£ 3,357,894	
19	Long-term home-based social care services	Ensuring people receive the necessary care provision to remain in their own homes	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 1,838,914	
20	Personalised budgeting and commissioning	Personalised budgeting re care plans and packages	1. Proactive care to those with complex needs	Social Care	Private Sector	Local Authority Better Care Grant	£ 1,100,800	
20	Personalised budgeting and commissioning	Personalised budgeting re care plans and packages	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 795,206	
21	Urgent community response	CHERRS - urgent response arrangement for care homes re. medical emergencies etc	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 212,614	
22	Long-term residential/nursing home care	Medicines Management - pharmacy techs doing care home audits, improving the way care homes handle	4. Preventing unnecessary hospital admissions	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 67,302	
23	Long-term residential/nursing home care	Nutrition Team - nutrition and hydration training and support to care homes across South Tees (Dietetic)	4. Preventing unnecessary hospital admissions	Community Health	Local Authority	NHS Minimum Contribution	£ 128,700	
24	End of life care	End of Life - CCG SPC nurse - developing training and support to care homes	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 32,881	
25	Long-term residential/nursing home care	CCG Infection Prevention Control Nurse training to care homes	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 33,787	
26	Discharge support and infrastructure	Trusted Assessor Lead - Trusted Assessor to supervise and lead the Trusted Assessor Team	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 53,159	
26	Discharge support and infrastructure	Trusted Assessor to facilitate patient discharge to care homes	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 55,968	
26	Discharge support and infrastructure	Trusted Assessor to facilitate patient discharge re mental health patients	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 51,145	
27	Discharge support and infrastructure	Social Worker - Transfer of Care Hub	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 54,007	
28	Evaluation and enabling integration	Single Point of Access - Multi disciplinary service hub to provide first point of contact	4. Preventing unnecessary hospital admissions	Community Health	Local Authority	NHS Minimum Contribution	£ 46,700	
28	Evaluation and enabling integration	Single Point of Access - Social Worker to help enable multi disciplinary service hub to provide first point of	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 54,749	
28	Evaluation and enabling integration	Single Point of Access - Co-ordinator and call handler to help enable multi disciplinary service hub to provide	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 63,664	
29	Evaluation and enabling integration	To manage and administer the BCF programme	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 114,551	
30	Discharge support and infrastructure	Hospital Social Work Team - to enable 7 day working and facilitate 7 day hospital discharges	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 206,541	
31	Discharge support and infrastructure	OTOC Officer -Officer dealing with the avoidance of delayed transfers of care	5. Timely discharge from hospital	Acute	Local Authority	NHS Minimum Contribution	£ 62,381	
32	Discharge support and infrastructure	OT staffing to facilitate, advise and support in respect of postural management in care homes.	5. Timely discharge from hospital	Community Health	Local Authority	NHS Minimum Contribution	£ 62,381	
33	Evaluation and enabling integration	Health Call - Remote clinical monitoring system for care homes	4. Preventing unnecessary hospital admissions	Community Health	NHS	NHS Minimum Contribution	£ 46,249	
34	Wider local support to promote prevention and independence	Frailty team for Emergency Department to reduce admissions of frail patients and help with on-going	1. Proactive care to those with complex needs	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 289,059	
35	Long-term residential/nursing home care	Falls Training - OT training for care home staff on falls prevention and management	4. Preventing unnecessary hospital admissions	Community Health	Local Authority	NHS Minimum Contribution	£ 49,004	
36	Discharge support and infrastructure	Transfer of Care Hub -Strategic System Lead and 4 Care Co-ordinators to expand an integrated transfer of	5. Timely discharge from hospital	Acute	NHS Acute Provider	NHS Minimum Contribution	£ 134,018	
37	Discharge support and infrastructure	A Home First community based service to ensure that patients are discharged home when medically	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 262,781	
38	Evaluation and enabling integration	Meds Support in the Community - To support home care providers with effective training and support to	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 49,804	
39	Evaluation and enabling integration	Contribution to the costs of DOLS BIA assessments and legal fees	1. Proactive care to those with complex needs	Social Care	Local Authority	Local Authority Better Care Grant	£ 203,950	
40	Evaluation and enabling integration	Tees Valley Digital Care Home Support - To provide IT digital support to care homes re. NHS mail, Microsoft Teams	4. Preventing unnecessary hospital admissions	Social Care	NHS Community Provider	NHS Minimum Contribution	£ 60,514	
41	Discharge support and infrastructure	OT staff to assess and facilitate discharges from care homes within a 4 week period	5. Timely discharge from hospital	Community Health	Local Authority	NHS Minimum Contribution	£ 106,371	
42	Discharge support and infrastructure	Effective Discharge - funding to facilitate streamlined D2A Pathway	5. Timely discharge from hospital	Continuing Care	Private Sector	NHS Minimum Contribution	£ 887,621	
42	Discharge support and infrastructure	Effective Discharge - funding to facilitate streamlined D2A Pathway	5. Timely discharge from hospital	Continuing Care	Private Sector	Local Authority Better Care Grant	£ 355,074	
43	Evaluation and enabling integration	Interim Travel Payments to Domiciliary care users	5. Timely discharge from hospital	Social Care	Private Sector	Local Authority Better Care Grant	£ 44,976	
44	Discharge support and infrastructure	Officer to facilitate proactive co-ordination of social care flow	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 51,410	
45	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	To fund overtime payments to Reablement Staff	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 16,464	
46	Discharge support and infrastructure	Tees Community Equipment Store - Additional resources to support increased discharge requirements	5. Timely discharge from hospital	Community Health	Local Authority	NHS Minimum Contribution	£ 93,700	
47	End of life care	A dedicated in-reach nurse at Teesside Hospice	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 27,277	
48	Discharge support and infrastructure	Funding to support patient transport for discharges	5. Timely discharge from hospital	Other	NHS	NHS Minimum Contribution	£ 130,339	
49	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Therapies Team at Meadowgate - Employment of an additional therapist to enhance the capacity of the existing	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 51,498	
50	Evaluation and enabling integration	South Tees Dom Care Medication Support Interface - Two pharmacy technician posts to support and	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 56,102	
51	Discharge support and infrastructure	2 Brokerage Officers to source and facilitate appropriate care placements and manage the increased D2A	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 76,637	
52	Discharge support and infrastructure	Enhanced Resource to improve Pathway Flow - An additional team manager within the Transfer of Care	5. Timely discharge from hospital	Acute	Local Authority	Local Authority Better Care Grant	£ 138,436	
53	Assistive technologies and equipment	Assistive Technology & Equipment - Digital Participation Services	2. Home adaptations and tech	Community Health	Local Authority	Local Authority Better Care Grant	£ 100,000	
54	Evaluation and enabling integration	Data Analyst - Data intergration to support commissioning	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 51,622	
55	Discharge support and infrastructure	Overtime for front line care staff to facilitate timely discharge arrangements and immediate after	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 318,000	
1	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Community Reablement and Independence Team	5. Timely discharge from hospital	Social Care	Local Authority	Local Authority Better Care Grant	£ 578,600	
56	Discharge support and infrastructure	VCS Service working alongside the Transfer of Care Hub to ensure that the full extent of community capacity	5. Timely discharge from hospital	Community Health	Charity / Voluntary Sector	Additional LA Contribution	£ 67,000	
56	Discharge support and infrastructure	Commissioning Officer to support VCS Service working alongside the Transfer of Care Hub to ensure that	5. Timely discharge from hospital	Community Health	Local Authority	Additional LA Contribution	£ 49,112	
57	Assistive technologies and equipment	The procurement of digitally compatable telecare equipment with the specific remit of providing support	2. Home adaptations and tech	Community Health	Private Sector	Additional LA Contribution	£ 45,000	
58	Discharge support and infrastructure	SCO post supporting discharge from Meadowgate Intermediate Care Centre	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 43,460	
59	Assistive technologies and equipment	ASK SARA - This initiative will promote adults' independence by using a self assessment tool to access equipment	2. Home adaptations and tech	Social Care	Local Authority	Additional LA Contribution	£ 12,000	
60	Discharge support and infrastructure	Implementation of the Access CM system will improve the pathway 1 discharge interface from the hospital	5. Timely discharge from hospital	Social Care	Private Sector	Additional LA Contribution	£ 53,000	
61	Discharge support and infrastructure	Best Interest Assessor - the Assessor will liaise with ward staff, linking into TOC Hub to support complex hospital	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 51,748	
62	Support to carers, including unpaid carers	We Care You Care - Website development to give information and guidance for all carers across the	3. Supporting unpaid carers	Social Care	Charity / Voluntary Sector	Additional LA Contribution	£ 21,345	
63	Discharge support and infrastructure	Administrative support to Hospital Social Work Team based at the Transfer Of Care Hub	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 27,030	
64	Discharge support and infrastructure	An additional Brokerage Officer to support the team to arrange more complex packages of care and	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 37,808	
65	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Project Officer in intermediate care and reablement services to implement and embed digital innovation in line	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 62,640	
66	Discharge support and infrastructure	Band 4 Rehabilitation Co-ordinator - This post would be both integrated across the secondary and primary	5. Timely discharge from hospital	Acute	NHS Acute Provider	Additional LA Contribution	£ 13,000	
67	Discharge support and infrastructure	Care Quality Assurance Officer - D2A and Complex Needs. Increasing capacity within the Care Quality team	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 43,466	
68	Assistive technologies and equipment	Digital Explorers - to support adults age 55+ to expand their knowledge and confidence in using digital	2. Home adaptations and tech	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 30,930	
69	Discharge support and infrastructure	Risk share re continuation of D2A funded schemes	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 3,499	
70	Discharge support and infrastructure	Risk share re continuation of D2A funded schemes	5. Timely discharge from hospital	Social Care	Local Authority	Additional LA Contribution	£ 211,220	
16	Disabled Facilities Grant related schemes	DFG related schemes funded from brought forward underspend	2. Home adaptations and tech	Social Care	Local Authority	Additional LA Contribution	£ 150,000	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS minimum:

- **Area of spend** selected as 'Social Care' and **Source of funding** selected as 'NHS Minimum Contribution'

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	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	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	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.
4	Wider support to promote prevention and independence	Prevention/early intervention	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 wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes 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
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term 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.
7	Long-term home-based social care services	Personalised care at home	Long-term 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 or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	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'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	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.
10	Long-term residential or nursing home care	Residential placements	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.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	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.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, 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. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	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.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Redcar and Cleveland

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,628	1,704	1,582	1,795	1,597	1,384	1,780	1,689	n/a	n/a	n/a	n/a	FOR THIS DRAFT SUBMISSION, we have adopted a 2% proxy for demographic growth and a do nothing approach for 2025/26 to arrive at the numbers included. This is to allow more time for detailed planning, discussions with FT and other colleagues and quantifying the expected impact of UCR, Virtual Ward and other admission avoidance schemes. There will be revised figures, ambitions and rationale in our final submission.
	Number of Admissions 65+	535	560	520	590	525	455	585	555	n/a	n/a	n/a	n/a	
	Population of 65+*	32,866	32,866	32,866	32,866	32,866	32,866	32,866	32,866	n/a	n/a	n/a	n/a	
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
	Rate	1,655	1,740	1,603	1,820	1,628	1,397	1,810	1,710	1,862	1,938	1,713	1,847	
	Number of Admissions 65+	544	572	527	598	535	459	595	562	612	637	563	607	
	Population of 65+	32,866	32,866	32,866	32,866	32,866	32,866	32,866	32,866	32,866	32,866	32,866	32,866	

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.64	0.61	0.55	n/a	n/a	n/a	n/a	FOR THE DRAFT SUBMISSION, we have just maintained the 2024/25 position and assumed no change in numerator or denominator. This is to allow more time for detailed planning, discussions with colleagues and assessment of the impact of our schemes which support effective discharges. There will be revised figures, ambitions and rationale in our final submission.
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	89.0%	88.7%	89.7%	n/a	n/a	n/a	n/a	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	5.8	5.4	5.3	n/a	n/a	n/a	n/a	
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan	
Average length of discharge delay for all acute adult patients	0.84	0.57	0.62	0.74	0.49	0.61	0.56	0.52	0.63	0.73	0.70	0.47	
Proportion of adult patients discharged from acute hospitals on their discharge ready date	87.6%	89.8%	90.5%	87.4%	90.3%	89.6%	89.6%	90.2%	89.4%	88.2%	86.8%	89.7%	
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.75	5.59	6.50	5.91	5.00	5.82	5.37	5.32	5.91	6.16	5.34	4.61	

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	785.0	730.2	739.4	240.4	146.0	155.2	197.8		To be completed for the final submission
	Number of admissions	258	240	243	79	48	51	65		
	Population of 65+*	32,866	32,866	32,866	32,866	32,866	32,866	32,866		

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence[2]	Percentage	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Redcar and Cleveland

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes			Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

BCF Capacity & Demand Template 2025-26

1. Guidance

Overview

This template has been unlocked to allow editing as required. It is optional to submit capacity & demand figures as per this template format and a customised format of this will be accepted.

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Pre-populated cells

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2. Once you are satisfied with the information entered the template should be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

3. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

This template follows the same format as last year and so contains all the previously asked for data points including demand (referrals), block and spot capacity, average duration of treatment and time from referral to treat all split by pathway. It is however only required that some form of data points are submitted to show projected demand (disaggregated by step-up and step-down) and capacity for intermediate care and other short term care. The additional data points on average treatment time, time to treat and spot/block capacity split are optional but have remained in case you may find these data points useful.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

List of data points in template:

3.1 C&D Step-down

Estimates of available capacity for each month of the year for each pathway.
Estimated average time between referral and commencement of service.
Expected discharges per pathway for each month, broken down by referral source.
Estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways.

3.2 C&D Step-up

Estimated capacity and demand per month for each service type.
Estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

HM Government

NHS England

Better Care Fund 2025-26 Capacity & Demand Template

2. Cover

Version 1.1

Health and Wellbeing Board:	Middlesbrough
Completed by:	Kathryn Warnock
E-mail:	kathryn.warnock@nhs.net
Contact number:	07766554805
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes

Once complete please send this template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'C&D - Name HWB' for example 'C&D - County Durham HWB'. Please also copy in your Better Care Manager.

<< Link to the Guidance sheet

Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: Middlesbrough

Step-down	Capacity surplus (not including spot purchasing)												Capacity surplus (including spot puchasing)											
Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	23	22	23	48	50	46	46	43	46	42	38	43	23	22	23	48	50	46	46	43	46	42	38	43
Short term domiciliary care (pathway 1)	6	7	6	7	7	6	7	6	7	7	2	7	6	7	6	7	7	6	7	6	7	7	2	7
Reablement & Rehabilitation in a bedded setting (pathway 2)	4	4	4	4	4	4	3	3	3	2	0	2	4	4	4	4	4	4	3	3	3	2	0	2
Other short term bedded care (pathway 2)	0	0	0	0	0	0	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)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
12	Contact Hours per package
14	Contact Hours per package
25	Average LoS (days)
23	Average LoS (days)
0	Average LoS (days)

Capacity - Step-down		Refreshed planned capacity (not including spot purchased capacity)												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	66	67	66	91	91	89	91	89	91	91	86	91	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated 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 capacity. Number of new packages commenced.	76	79	76	79	79	76	79	76	79	79	70	79	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	17	17	17	17	17	17	17	17	17	17	15	17	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated 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 capacity. Number of new packages commenced.	41	42	41	42	42	41	42	41	42	42	38	42	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated 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 capacity. Number of new packages commenced.	0	0	0	0	0	0	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)	Estimated 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												

Demand - Step-down		Please enter refreshed expected no. of referrals:											
Pathway	Trust Referral Source	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Expected Step-down:	Total Step-down	**140**	**146**	**141**	**140**	**135**	**140**	**148**	**151**	**148**	**159**	**156**	**156**
Reablement & Rehabilitation at home (pathway 1)	Total	**43**	**45**	**43**	**43**	**41**	**43**	**45**	**46**	**45**	**49**	**48**	**48**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	40	42	40	40	39	41	43	44	43	46	46	45
	OTHER	3	3	3	3	2	2	2	2	2	3	2	3
	(blank)												
	(blank)												
Short term domiciliary care (pathway 1)	Total	**70**	**72**	**70**	**72**	**72**	**70**	**72**	**70**	**72**	**72**	**68**	**72**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	70	72	70	72	72	70	72	70	72	72	68	72
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**13**	**13**	**13**	**13**	**13**	**13**	**14**	**14**	**14**	**15**	**15**	**15**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	13	13	13	13	13	13	14	14	14	15	15	15
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												
Other short term bedded care (pathway 2)	Total	**41**	**42**	**41**	**42**	**42**	**41**	**42**	**41**	**42**	**42**	**38**	**42**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	41	42	41	42	42	41	42	41	42	42	38	42
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												

Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: Middlesbrough

Step-up **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	22	22	22	21	21	21	21	21	21	21	19	21
Reablement & Rehabilitation in a bedded setting	2	3	2	3	3	2	3	2	3	3	3	3
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours	
Full Year	Units
0	Contact Hours
12	Contact Hours
25	Average LoS
0	Contact Hours

Capacity - Step-up

Please enter refreshed expected capacity:

Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	42	43	42	41	41	40	41	40	41	41	37	41
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	17	18	17	18	18	17	18	17	18	18	17	18
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Demand - Step-up

Please enter refreshed expected no. of referrals:

Service Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	20	21	20	20	20	19	20	19	20	20	18	20
Reablement & Rehabilitation in a bedded setting	15	15	15	15	15	15	15	15	15	15	14	15
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

BCF Capacity & Demand Template 2025-26

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Estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways.

3.2 C&D Step-up

Estimated capacity and demand per month for each service type.
Estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

Better Care Fund 2025-26 Capacity & Demand Template

2. Cover

HM Government

NHS England

Version 1.1

Health and Wellbeing Board:	Redcar and Cleveland
Completed by:	Kathryn Warnock
E-mail:	kathryn.warnock@nhs.net
Contact number:	07766554805
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes

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Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: Redcar and Cleveland

Step-down	Capacity surplus (not including spot purchasing)												Capacity surplus (including spot puchasing)											
Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	51	51	55	57	58	57	54	53	54	52	52	53	51	51	55	57	58	57	54	53	54	52	52	53
Short term domiciliary care (pathway 1)	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Reablement & Rehabilitation in a bedded setting (pathway 2)	4	4	5	4	5	4	3	2	2	2	2	2	4	4	5	4	5	4	3	2	2	2	2	2
Other short term bedded care (pathway 2)	0	0	0	0	0	0	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)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours per episode of care	
Full Year	Units
8.1	Contact Hours per package
10.4	Contact Hours per package
31.3	Average LoS (days)
28.2	Average LoS (days)
42	Average LoS (days)

Capacity - Step-down		Refreshed planned capacity (not including spot purchased capacity)												Capacity that you expect to secure through spot purchasing											
Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	92	93	96	98	98	98	98	98	98	98	98	98	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Estimated 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	2.6	2.6	2.6	2.6	2.6	2.6												
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	8	8	8	8	8	8	8	8	8	8	8	8	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	4	4	4	4	4	4	4	4	4	4	4	4												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	25	25	25	25	25	25	25	25	25	25	25	25	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Estimated 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	3.2	3.2	3.2	3.2	3.2	3.2												
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	15	15	15	15	15	15	15	15	15	15	15	15	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased)	5	5	5	5	5	5	5	5	5	5	5	5												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	5	5	5	6	5	5	6	7	7	8	8	8	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)	Estimated 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	6.5	6.5	6.5	6.5	6.5	6.5												

Demand - Step-down		Please enter refreshed expected no. of referrals:											
Pathway	Trust Referral Source	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Expected Step-down:	Total Step-down	**133**	**136**	**132**	**134**	**130**	**134**	**142**	**146**	**144**	**151**	**150**	**148**
Reablement & Rehabilitation at home (pathway 1)	Total	**41**	**42**	**41**	**41**	**40**	**41**	**44**	**45**	**44**	**46**	**46**	**45**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	39	40	39	39	38	39	42	43	42	44	44	43
	OTHER	2	2	2	2	2	2	2	2	2	2	2	2
	(blank)												
	(blank)												
Short term domiciliary care (pathway 1)	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												
Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	**21**	**21**	**20**	**21**	**20**	**21**	**22**	**23**	**23**	**23**	**23**	**23**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	21	21	20	21	20	21	22	23	23	23	23	23
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												
Other short term bedded care (pathway 2)	Total	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	15	15	15	15	15	15	15	15	15	15	15	15
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	**5**	**5**	**5**	**6**	**5**	**5**	**6**	**7**	**7**	**8**	**8**	**8**
	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	5	5	5	6	5	5	6	7	7	8	8	8
	OTHER	0	0	0	0	0	0	0	0	0	0	0	0
	(blank)												
	(blank)												

Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: Redcar and Cleveland

Step-up **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Average LoS/Contact Hours

Full Year	Units
10.4	Contact Hours
8.1	Contact Hours
31.3	Average LoS
0	Contact Hours

Capacity - Step-up

Please enter refreshed expected capacity:

Service Area	Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	Monthly capacity. Number of new clients.	10	10	10	10	10	10	10	10	10	10	10	10
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	10	10	10	10	10	10	10	10	10	10	10	10
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	6	6	6	6	6	6	6	6	6	6	6	6
Other short-term social care	Monthly capacity. Number of new clients.	120	120	120	120	120	120	120	120	120	120	120	120

Demand - Step-up

Please enter refreshed expected no. of referrals:

Service Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Social support (including VCS)	10	10	10	10	10	10	10	10	10	10	10	10
Reablement & Rehabilitation at home	10	10	10	10	10	10	10	10	10	10	10	10
Reablement & Rehabilitation in a bedded setting	6	6	6	6	6	6	6	6	6	6	6	6
Other short-term social care	120	120	120	120	120	120	120	120	120	120	120	120

DPH Annual Report [Extract]

1 Introduction

This report uses the experience and learning from the You've Got This (YGT) programme to better understand how we need to work together across agencies and communities to achieve the improvements in wellbeing articulated in the Mission-led Health and Wellbeing Strategy.

The learning also has broader application for all organisations in South Tees who are developing "transformation" programmes.

The fundamental argument is that to deliver the Missions we have to create a structure that inspires and supports new ways of working. This structure should consider as a minimum: leadership across the system; cross-agency collaboration built on insight and information sharing to build shared understanding; engaging communities; how to encourage calculated risk- taking, experimentation and development of innovative solutions; embracing a learning approach and the generation of new perspectives and new thinking.

A Mission-based approach requires 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 range of diverse projects, activities and initiatives designed for long-term transformation together with communities, people with lived experience and key actors in the system.

We need to consider how we **break silos and perverse incentives within and between agencies** and **coordinate action across programmes and agencies**. Complex organisational structures, with rigid formal processes, limit the flow of information, reduce openness and constrain creativity. If we want to achieve improvements in population-level wellbeing and reduce inequalities then we need to act and behave differently.

2 You've Got This – Background

YGT is a Sport England Place Partnership, with a vision of "**Active Lives as a Way of Life**" that aims to deliver Sport England's key outcomes: reducing inactivity, increasing activity, positive experiences for children and young people and tackling inequalities.

YGT has challenged traditional ways of working, taking a place-based systems approach driven by insight and learning, collaboration and distributed leadership, framed within the context of physical activity. Understanding the complex challenges of our place has shaped the approach to the work, and also built trust by aligning YGT to local challenges and describing how physical activity can help address them.

The YGT programme of work has three main themes:

- **Influencing Ways of Working**: positively challenging to influence change, developing more collaborative approaches, developing distributed leadership and creating a learning culture that sits across the whole programme.
- **Communities of Interest**: areas of work where physical activity can add value to existing work and boost health outcomes whilst also building a value of physical activity in the organisations themselves.
- **Community Focus Area**, four wards that are in the top 10% most disadvantaged in England: Grangetown, South Bank, North Ormesby, and Brambles & Thorntree; where a more community-led approach to embedding of physical activity could be tested.

2.1.1 Influencing Ways of Working: Organisational Capacity Building

Training professionals, empowering them to tackle patients' lack of motivation to be physically active through Motivational Interviewing techniques. Motivational Interviewing is a collaborative, goal-oriented communication style with particular attention to the language of change.

YGT has worked with **Social Prescribers** in Redcar and Cleveland to support them to shift the emphasis of their work from "fixing" to supporting patients to decide on their own choices, opening up opportunities to raise the value of physical activity.

Holiday Activities and Food **(HAF) Programme Physical Activity Training** was developed based on insights from the HAF staff team and Young Inspectors. Whilst food provision generally met School Food Standards, the quality of the physical activity offerings varied widely. YGT developed a programme to upskill HAF providers, resulting in a significant improvement in inclusive physical activity delivery quality.

Creating Active Schools (CAS) is supporting thirty schools over three years, with the more established schools acting as mentors for new schools. CAS embeds physical activity throughout the school agenda from a policy and governor level down to the playground and beyond the school day. Case Study 1 describes this work in greater depth.

Allied to CAS, **The Great Outdoors** focuses on embedding the importance and need around the capacity of outdoor activity and forest school provision with schools through the training and upskilling of school and community staff. It also develops plans for schools to enhance their open spaces to meet their physical activity needs.

2.1.2 Influencing Ways of Working: Policy Development in Planning and Transport Planning

YGT have worked to embed a revised Health and Wellbeing Policy into the Local Plan in Middlesbrough and co-designing their first Health Impact Assessment (HIA) toolkit, with an emphasis on physical activity. HIA is a process that identifies the health and well-being impacts of any plan or development project. The HIA will recommend measures to maximise positive impacts; minimise negative impacts; and reduce health inequalities.

YGT are moving on to Redcar and Cleveland Borough Council to incorporate into the forthcoming review of the Local Plan an emphasis on physical activity and health, with a particular focus on childhood obesity, and the creation of an equivalent HIA toolkit. This workstream is considered in detail in Case Study 2.

2.1.3 Communities of Interest: Clinical Workstreams

The Communities of Interest focussed on existing pieces of work where physical activity could add value and where those involved in the work could develop a greater value of physical activity, embedding it into the work and wider organisational setting. YGT focussed on engaging these organisational partners in understanding more about how different ways of working could impact their practice.

PREP-WELL was a partnership with James Cook University Hospital (JCUH) in Middlesbrough. The programme tested the importance of “prehabilitation” – supporting patients to get fit for surgery - and was the UK's first comprehensive supervised community-based service supporting patients to access progressive support for several pre-operative risk factors in a single setting in the months before surgery. YGT focussed on the physical activity offer, alongside other interventions, such as diet, mental well-being and alcohol consumption. The learning from PREP-WELL has also been applied to Waiting Well, a holistic programme funded by the NHS nationally to support the health and wellbeing of patients awaiting a range of operations and procedures to improve their well-being before treatment. Case Study 3 considers PREP-WELL in greater depth.

Type 2 Diabetes Remission programme aimed to develop a robust patient-centred physical activity offer alongside a nutritional element to enable patients living with Type 2 Diabetes to move into remission. Everyone Active provided personalised support to patients on physical activity, building on patients’ own interests rather than a standard pathway into Exercise on Referral. This both informed new physical activity decisions and ways of working for this service and shaped Everyone Active’s approach to activity provision for communities across everything they do regionally.

Active Hospitals is a programme that aims to support hospitals to become places that encourage and support physical activity. The programme is based on insight, including patient insight; staff culture around physical activity; and considers hospital policies and protocols around physical activity; and an Active Environmental Audit of the hospital. The insight will then be used to inform priority actions within JCUH.

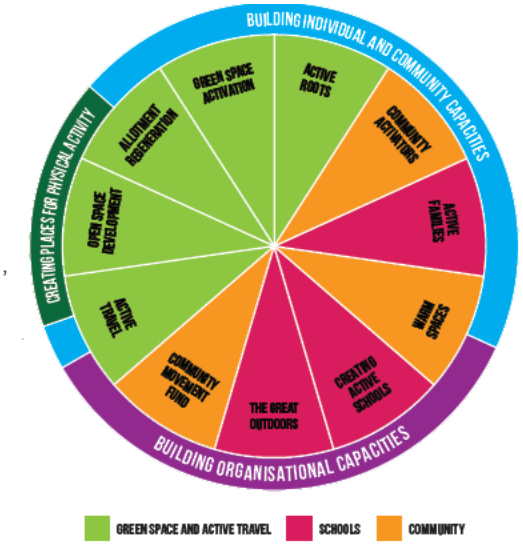
Flippin’ Pain has been developed to change the way people think about, talk about, and treat chronic pain – as perceptions of pain are a key barrier to physical activity. Flippin’ Pain engages and empowers communities to rethink pain, re-engage, recover and become more active. This work received national recognition when it was officially named the "Gold" winner of the Most Impactful Partnership in Preventative Healthcare at the HSJ Partnership Awards 2024. Case Study 4 considers Flippin’ Pain in more detail.

2.1.4 Community Focus Area

The Community Focus Area represents four wards, clustered around the boundary of the two boroughs where the challenges are even greater.

YGT understood that the ward boundaries need to be “leaky”, as communities access facilities such as schools, green spaces and shopping facilities beyond the bounds of the wards. This flex has also enabled the programme to engage meaningfully with other initiatives from a different geography.

For example, the Eston Town Deal, a significant capital and revenue initiative that extends across the whole of Greater Eston, including Grangetown and South Bank. The wheel below defines the principal work streams in the Community Focus Area.



Active Travel combines interventions aimed at individuals, such as cycle maintenance workshops, with more strategic measures, such as improving cycle security in venues. These measures are designed to ensure the safety and convenience of active travel. It links closely with the individual behaviour change work led by Sustrans in South Tees and a capital programme of work as part of Tees Valley Combined Authority (TVCA) and Levelling Up Fund (LUF).

Open Spaces Development addresses the complex issues of accessing open spaces across the CFA. It supports the Councils in developing their open spaces in our CFA in a community-led way, linking to capital developments to open spaces in Grangetown and South Bank through the Levelling Up Fund and Town Deal. This includes more detailed engagement around proposals for Eston Recreation Ground.

Allotment Regeneration involves mapping allotment sites and exploring opportunities to engage more diverse groups in them, including through capital investment.

3 Leadership

3.1 YGT Approach to Leadership

The YGT approach to leadership recognises that building the perceived value of physical activity alone, in a place with significant deep rooted structural issues, could not lever the change in levels of physical activity. Leadership is critical to set direction and build the conditions for change.

3.1.1 Distributed Leadership

The original model of distributing the core team across VCS partners was perhaps naïve as a vision of how leadership could be embedded, the movement of staff between partners and the Accountable Body (Redcar & Cleveland Council) were necessary explorations to achieve a workable model of influence and leadership.

Whilst VCS hosting provided tangible benefits, it was challenging to create deeper influence, reflecting a much broader issue of VCS influence across the system on other priorities in South Tees. Deeper embedding in a public sector accountable body placed the work of the programme closer to policy-level decision-making, for example, in areas such as Public Health and Planning.

In terms of distributing leadership, the Programme Director's and Creating Active and Healthy Places Lead's posts have driven significant change in ways of working, including the value placed on physical activity. The greatest benefits have been accrued through placing the Programme Director within Public Health South Tees. The Active and Healthy Places Lead has built direct rapport with Planners and Transport Planners within both authorities, which has developed a significant contribution to creating active environments by influencing policy development.

3.1.2 Building Distributed Leadership Through the Exchange

The development of The Exchange from a traditional Programme Delivery Partnership and the development of Ambassadors committed to a common purpose is potentially the most significant change in influencing our partner organisations (see section 6). The Exchange is now the mechanism for reaching out to and influencing the behaviour of partner organisations. It has enabled YGT to recognise the importance of what happens outside of the room, creating collaboration, and how The Exchange can be built as less of a meeting of partners and more as a "movement". The approach is also a significant part of the distributed leadership model.

The way of working through the Exchange demonstrates the programme's intention to recognise leadership across the system and cede elements of control to other organisations. The relationship with the Core Staff Team is relational, not transactional, so the nature of the leadership is transformed from a traditional approach focussed on accountability and builds capacity and leadership in partner organisations.

The Exchange working groups are supported but not led by YGT so that the leadership passes to and is distributed across Ambassadors. The creation of the exchange and the role of Ambassadors is described further in section 6.

3.1.3 Building Distributed Leadership Through Collaborative Commissioning

Competitive procurement processes were identified as a barrier to collaboration, pitting organisations in the Exchange against one another, rather than encouraging them to combine their strengths. Building on previous learning, an alternative Collaborative Commissioning Model was established with Redcar & Cleveland Borough Council's Procurement Team. This model facilitates a more collaborative approach within The Exchange for most commissions.

The **Collaborative Commissioning** Model has been a vital feature of the delivery approach. It is primarily a tool for maximising outcomes through a collaborative approach to commissioning (see section 6). However, it has also been a model to facilitate and develop distributed and shared leadership as part of the process.

4 Learning Approach

4.1 YGT Approach to Learning

As a Place Partnership, YGT have committed over the last six years to an ongoing process of insight gathering, learning and evaluation.

The YGT learning model is based across three areas:

- Developing and sharing a deep understanding of people and place (see section 5).
- Process evaluation of systemic change – building understanding of what works, for whom, in what contexts, in what respects and how
- Building learning and evaluation capacity and capability, working towards creating a learning culture – including Demonstrating Value.

4.1.1 Process Evaluation of Systemic Change

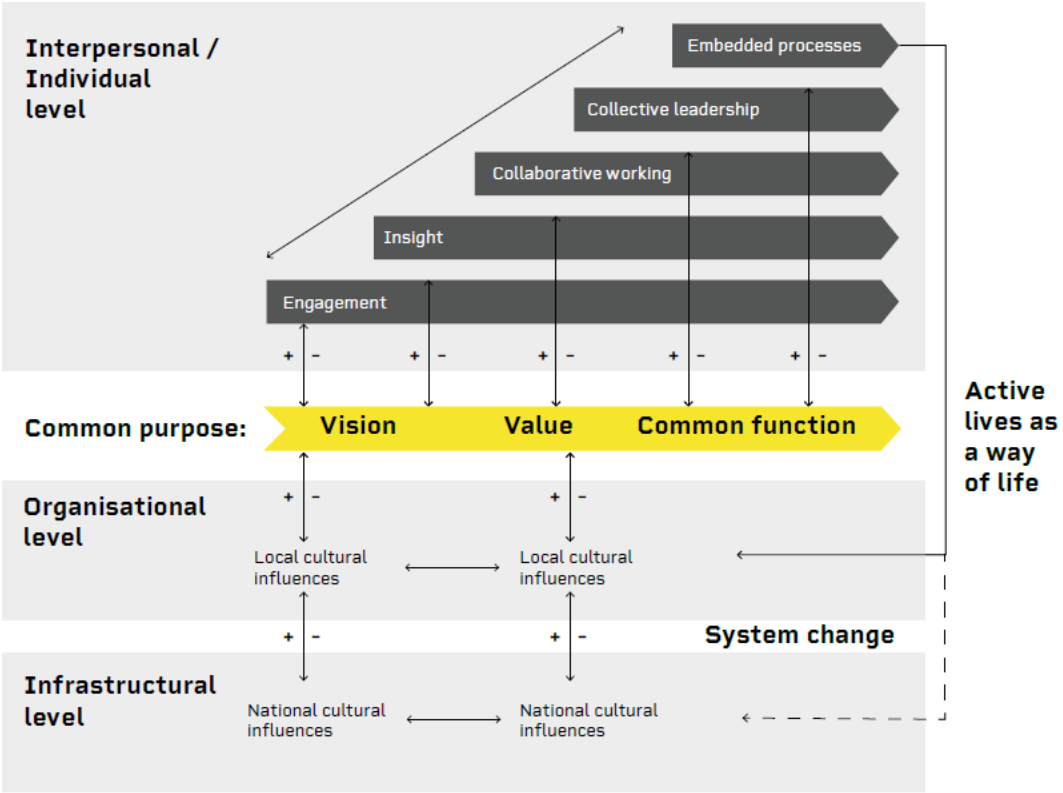
Sheffield Hallam University was commissioned to undertake continuous Process Evaluation and a full-time Researcher was fully embedded in the Core Team. Process evaluation aims to generate a detailed understanding the mechanisms through which an intervention produces change. Process evaluation can also explain why an intervention failed and indicate what might need to be redesigned. The Embedded Researcher has engaged with Exchange members, commissioned workstreams and other stakeholders to ensure that the learning is holistic, authentic and focussed on understanding the systemic changes that are taking place, how and why.

4.1.2 Reflective Practice

Reflective Practice has become increasingly embedded within the work of YGT, including with the YGT Core Team and the Process Evaluation Team and the Programme Management Office (PMO). The use of reflective practice has been extended and embedded within the Public Health South Tees Management Team by the YGT Programme Director.

4.1.3 Common Purpose Model

Whole systems change is overwhelmingly complex, often with ever-changing interconnections between different people in different roles and places. The Common Purpose Model provides a framework to guide working practices and learning, illustrating three key elements which are considered to sustain a common purpose: Vision, Value and Collective Function.



The initial activities of YGT were primarily aimed at influencing or connecting a wide range of people to engage with the vision, see its value and then act in line with it. Most of these activities described below operate at an individual or interpersonal level. People occupy many different roles within the system including senior leadership, policy makers, management, frontline workers across different specialisms and sectors as well as with individuals in the target wards. The core activities are defined as follows:

- **Engagement**: intended to start a relationship of some kind.
- **Insight**: to gain a deep understanding of (and empathy towards) someone else's situation. YGT used behaviour change frameworks to understand the lives of the people in the target wards as well as stakeholders working or influencing those people.
- **Collaborative working**: activities which bring skills, expertise, networks together on a project. This includes collaboration internally, as well as collaboration between partners brokered by YGT.
- **Collective leadership**: activities or actions where people are working together towards the same vision. This may differ from collaborative working in terms of the higher level of commitment, trust, shared power, shared responsibility for achieving the aim, shared accountability and shared successes.
- **Embedded processes**: formalising the new ways of working so that they can remain active beyond the individuals and relationships in YGT and the Exchange and create a legacy.

Individual behaviour and interpersonal relations are influenced by an individuals' skills, history of working together, characteristics and demography. The final elements of the model are the external influences that facilitate or constrain progress, separated into cultural influences and structural influences:

4.1.4 Theory of Change

The Theory of Change is based on the evolution of thinking, building on the combined learning over the last six years of the programme. The development of the Theory of Change has engaged with the Programme Management Office, key partners including Public Health South Tees and Tees Valley Sport, and The Exchange partnership.

Recognising the complexity of the issues impacting on individual behaviours, YGT are using a place-based whole system approach to create the conditions for people to build activity into their daily lives. Whilst ultimately individuals change their own behaviour, for this to take place at scale, the model recognises the need to inspire systemic change and empower change within organisations. Behavioural change models can be applied to organisations as well as individuals. For individuals, the three elements of behavioural change, capability, opportunity and motivation, are all vested in the one person; for organisations, these three elements may be held by different people.

Organisational behaviour change is more than about developing a value of physical activity within their work, it is equally about rethinking ways of working that enable change to happen. The new Theory of Change recognises that YGT and the broader system had a set of foundations in their own ways of working, for supporting and enabling change to happen:

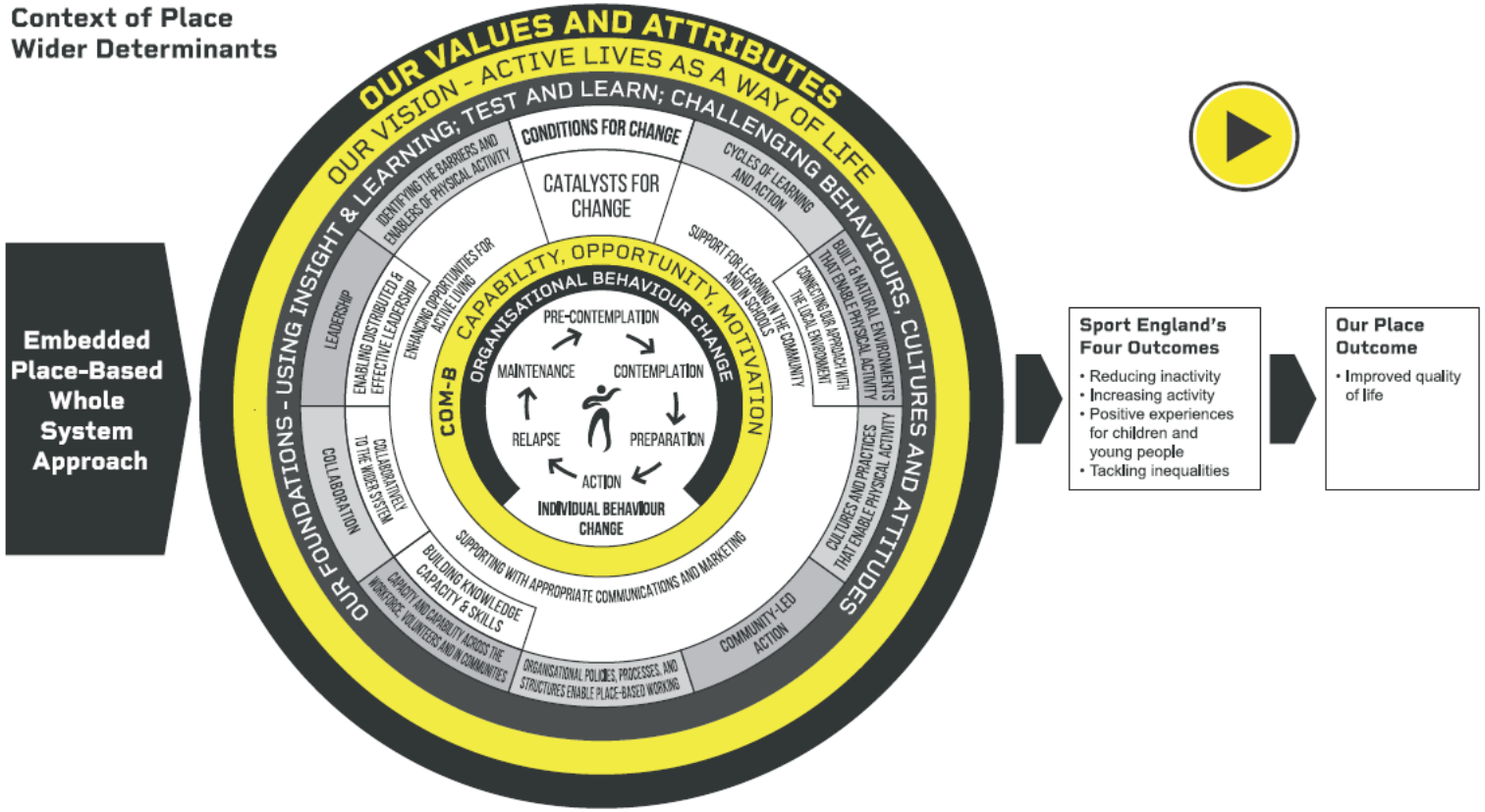
- **Insight and learning** – a crafted combination of quantitative data and qualitative insight to dig deep into issues that influence physical activity behaviours and a recognition of the importance of all learning in shaping future work.

- **Test and learn** – open to exploring different approaches, learning from the findings and adapting and refining approaches in response.
- **Challenging behaviours, cultures and attitudes** – a positive process enabling partners to understand how their behaviours impact on people's ability to be active and influencing and supporting their own journey of change.

YGT, with partners from The Exchange, have identified five conditions which will have the most impact in bringing about organisational change and working towards Sport England's four outcomes and the place outcome (these are reflected in the "catalysts for change" ring):

- **Cycles of learning and action** – the demonstrable impact from commissioned work and our own behaviours as a programme of constantly testing, learning, and adapting the work in response to observed insight and learning.
- **Collaboration** – insight from The Exchange and commissioned workstreams of the benefits and opportunities of collaborative, rather, than transactional, approaches to the work.
- **Leadership** – impactful change through others taking the lead to either build a value of physical activity into their own work (for example HAF) or start to shift ways of working (for example, new approaches to Joint Strategic Needs Assessments).
- **Capacity and capability across the workforce, volunteers and in communities** – ensuring organisations have the capacity and capability for change, such as providing Motivational Interviewing training for partners and providing capacity building around physical activity for HAF providers.
- **Built and natural environments that enable physical activity** – creating quality spaces and addressing barriers such as ASB, linking closely with the Local Plan and Development Plan process.

Theory of Change



The consolidation of learning across all the Place Partnerships in the Sport England programme has developed **nine conditions for change** (described in the circle above). YGT have cross-referenced these against the foundations described above and catalysts for change and identified clear synergies between the two. This cross-referencing local learning with national learning is important to both reflect learning from elsewhere and ensure that the model is built on local learning.

5 Engaging Communities

5.1 Developing a Deep Understanding of People and Place

Developing and sharing a deep understanding of people and place is a fundamental element of the YGT learning model (see section 4 above). YGT recognised the need to add value to the "what" (quantitative) with the "why" and the "how" (qualitative). Although the quantitative data provided information on activity levels and social conditions, alone it wouldn't support YGT to identify key audiences and understand their needs. The programme explored two methods to gather insight and provide learning through qualitative techniques: Storytelling and Social Listening.

5.1.1 Storytelling

Storytelling is a technique used to surface the outcomes from participants' experiences and viewpoints by recording and analysing narratives. Storytelling provides meaningful information that highlights crucial learning points, including unintentional outcomes. It also adds value to quantitative data, giving a richer, more nuanced, complex narrative that more accurately reflects lived experience. Over five years, the small, locally based, and trusted Storytelling Team has collected insight and evaluated interventions from both local communities and professional audiences.

Storytelling has been widely adopted by organisations in place and YGT funded Storytelling training programmes for Ambassadors. Underpinning the development of understanding of place, are also the insight contributions from Ambassadors and YGT engagement with diverse partnerships and thematic groups in place.

5.1.2 Social Listening

Social Listening uses Artificial Intelligence to monitor social media channels to track trends, campaigns and engagement. YGT have worked with Word Nerds, a company that uses AI to analyse online conversations to build a platform to track how and what people are saying about physical activity and other determinants of health. Reviewing both the volume of conversations about a topic and the sentiment attached to the comment (positive, negative, or neutral). The platform first showed its value during the pandemic because YGT could see what issues and themes mattered most to communities.

5.1.3 Small Grants to Engage Community Groups

Another methodology to engage communities through community organisations has been the two small grant schemes, Your Active Living Fund (YALF) and Community Movement Fund (CMF). These schemes have dug deep into communities, with a particular focus on supporting projects and organisations where physical activity is not the primary focus. YALF has operated on a South Tees footprint, supporting 26 projects, whilst CMF has been restricted to the target wards, supporting 19 projects.

6 Collaboration

6.1 YGT Approach

At the outset of the work, YGT recognised that approaches to collaboration in place were often transactional, siloed and based on accountability. The YGT programme enabled an exploration of new ways of collaborating that were more relational and would play to the strengths of different partners.

6.1.1 Reimagining the Core Team

Maintaining a small Core Staff Team to guide the work enabled investment of additional commissioned resources within Ambassador organisations. This fostered co-creation and a move towards increasing capacity and sustainability, providing a clear statement of intent of the different approach.

An unexpected impact has been to shift power to the wider partnership. The leadership role of the Core Staff Team is reduced, as delivery staff are not from the Core Team, and there are more significant opportunities for the delivery collaborations to reimagine and reinvent the work creatively as they are specialists close to the work (see Case Study 1 - Creating Active Schools), where the delivery partnership significantly adapted the model through learning from initial engagement with schools to simplify the structure and ultimately create a more locally appropriate approach.

6.1.2 Rethinking Partnership Structure – Development of the Exchange

The YGT Process Learning has identified the development of The Exchange from a traditional Programme Delivery Partnership and the development of Ambassadors committed to a Common Purpose as potentially the most significant change in influencing our partner organisations.

The Exchange is now the mechanism for reaching out to and influencing the behaviour of partner organisations. It has enabled YGT to recognise the importance of what happens outside of the room, creating collaboration, and how The Exchange can be built as less of a meeting of partners and more as a movement.

Members of The Exchange are the YGT **Ambassadors**. They share a simple set of values, each making an annual pledge describing their contribution to the vision. Distributed leadership plays an important role, with Ambassadors encouraged to collaborate outside the room, developing relationships without direct involvement from YGT.

Rather than centralising power through a single organisation, this approach recognises that leadership can emerge from various levels and roles within the system, allowing a more flexible and inclusive approach to decision-making. It also empowers Ambassadors to take the initiative, contribute their expertise, and foster a sense of ownership in getting people active.

6.1.3 A New Approach to Commissioning

Competitive tendering processes were identified as a barrier to collaboration, pitting organisations against one another, rather than encouraging them to combine their strengths. Building on previous learning, an alternative Collaborative Commissioning Model was established with Redcar & Cleveland Borough Council's Procurement Team.

The interplay between The Exchange and Collaborative Commissioning has shifted ways of working and created impact:

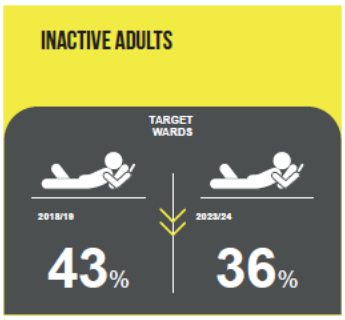
- Encourages Exchange members to work together to develop workstreams based on insight rather than competitive commissioning around a tightly defined specification.
- Worked with the Council's procurement and legal teams to develop an understanding of a loosely defined impact-led contracting approach that avoids simple output-driven measures.
- Bringing together organisations with complementary skills. The Warm Spaces commission, for example, brought together a range of delivery partners to create a diverse offer attractive to different community venues.
- Commissioning open to smaller organisations that would not normally be involved in procurement processes, broadening the skills within commissions and building capacity in the VCS.

7 What has the YGT Approach Achieved?

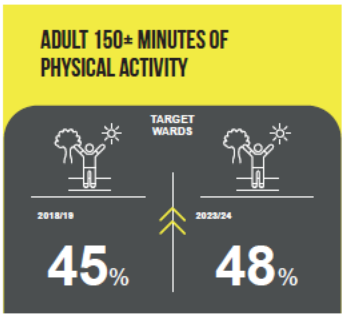
7.1 Reducing Inactivity and Increasing Activity

Given the significant levels of inactivity locally, YGT have prioritised the high-level Sport England outcome of **Reducing Inactivity**, alongside the closely allied **Tackling Inequalities**. This section considers Reducing Inactivity and Increasing Activity together, at a borough-wide level and within the target wards, as well as in one of the YGT clinical programmes, PREP-WELL.

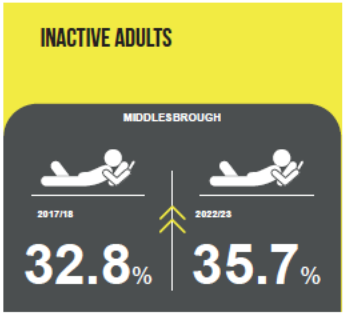
Within the target wards between 2018/19 and 2023/24, we have demonstrated a decrease in ***inactivity*** of 7% in inactive adults, against a rise in an equivalent local area.

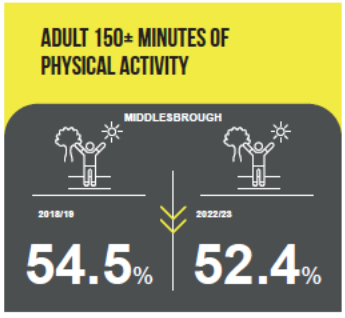


Concurrently, there has been an increase of 3% in ***activity*** rates in adults in the target wards in the same period, against a fall in an equivalent local area.



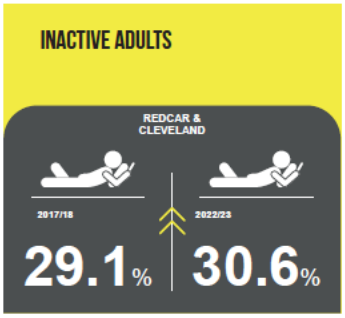
The positive picture in the Community Focus Area has not been replicated borough-wide, with increases in ***inactivity*** and decreases in ***activity*** in the adult population.

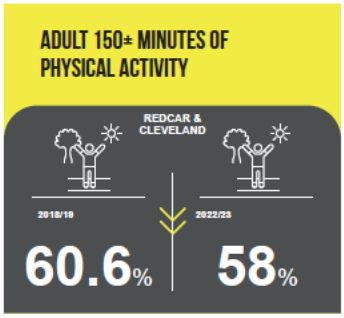




The figures for inactivity have increased slightly and the figures for physical activity have increased slightly in both Middlesbrough and

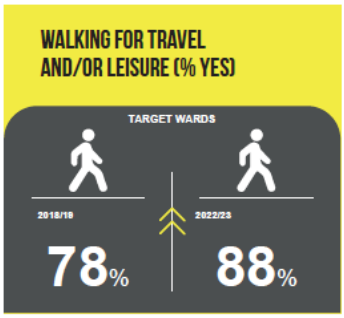
Redcar & Cleveland. The changes are greater for Middlesbrough.

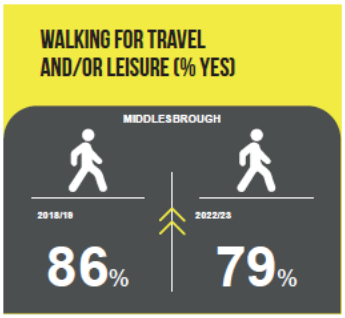


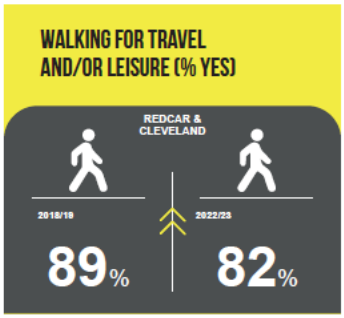


These borough-wide data reflect some of the wider challenges facing South Tees, particularly Middlesbrough, related to deprivation and poverty. Whilst disappointing, they point to the need for further intervention particularly at a policy level to tackle to wider drivers of inequality alongside measures to tackle physical activity inequalities.

Within the Community Focus Area (CFA) [target wards in the graphic], YGT also measured changes in different aspects of physical activity. **Walking** increased in the CFA during COVID-19 and has since remained above borough levels and an equivalent local area. There has been a 10% increase in walking for travel or leisure in the CFA, against falling rates across both Boroughs over the same period.







8 Learning Points

1. Leadership is often considered in a hierarchical sense, with the value and importance of leadership perceived to increase as you move up the hierarchy. YGT have demonstrated that different types of leadership exist throughout organisations and in communities and influencing leadership much more broadly is necessary to achieve change within and across organisations.

2. Traditional Partnership models of delivery that focus on compliance and accountability can often exclude creativity and discovery and building shared ownership. These models may drive a transactional approach and miss the opportunity to develop relationships within and between people in organisations that can also influence behaviours beyond the immediate work. This in turn can open up new and different areas to progress the aspirations of the Partnership.

3. The processes we use to deliver the outcomes we want to achieve are important, but can often act against achieving those outcomes. Competitive procurement processes are often a barrier to collaboration, pitting potential partners against each other, rather than encouraging them to combine their strengths. Deeper consideration of these processes and organisational structures and their impact on achieving the desired outcomes is necessary to fully realise the benefits of partnership working.

4. How organisations invest in programmes of work and where resources are deployed is important to the development of broader coalitions, insight and influence across partners to achieve the outcomes.

5. VCS organisations hold expertise, insight and commitment for their communities, but their influence over policy development and decision making in Councils and the NHS is limited.

6. A clear vision, or Mission, is important, but not sufficient on it's own to drive Common Purpose across and within organisations.

7. The development of a learning approach should be based on a clear understanding of current ways of working that undervalue learning – with often a narrow focus on operational performance and thin single-agency metrics. A learning approach cannot flourish within a culture focussed on compliance, accountability and policing the boundaries between organisations.

8. Embedding practices into ways of working, such as reflective practice is important to building learning as part of an on-going approach rather than a series of set-piece events.

9. Systems change is complex, often with ever-changing interconnections between different people in different roles and places. Models (like the Common Purpose model and the Logic Model) can help to build understanding of how interventions and approaches are working (or not working).

10. Insight and understanding of how issues manifest themselves in communities and the opportunities and barriers to progress is critical to success. This requires investment, work and time to build trust in communities and with partner organisations.

CASE STUDY

Place-based Whole Systems Work with Schools in South Tees

PLACE-BASED WHOLE SYSTEMS WORK WITH SCHOOLS IN SOUTH TEES

The Creating Active Schools (CAS) Framework is a research-based whole-school behaviour change approach to increasing and improving physical activity in schools. It was designed collaboratively by practitioners, policymakers, and researchers, including staff from YGT and our Ambassador organisation, Redcar & Eston School Sport Partnership (RESSP).

The framework provides a whole school strategy toolkit that enables schools to determine the priorities and training required to become active schools. It supports a school's embedding of physical activity in policies, systems, behaviours, and environments so that it becomes everyone's responsibility, from pupils to staff, parents, and governors.

Following the creation of the CAS framework, YGT and Tees Valley Sport (TVS) developed a collaborative partnership to deliver an initial CAS pilot across South Tees. This would be a test and learn approach, understanding how the framework would land locally and how the approach could evolve to maximise physical activity in schools.

Together, they recognised the need to reframe what physical activity can mean for schools and provide senior leaders with a structure that aims to transform the culture of physical activity within their setting and uses movement to improve academic and holistic outcomes for pupils.

The initial focus was on only six schools, to allow time and capacity to fully understand each school's needs, gather valuable insight and test and adapt their approach. From there, the model was developed further in response to leaning and rolled out to more schools.

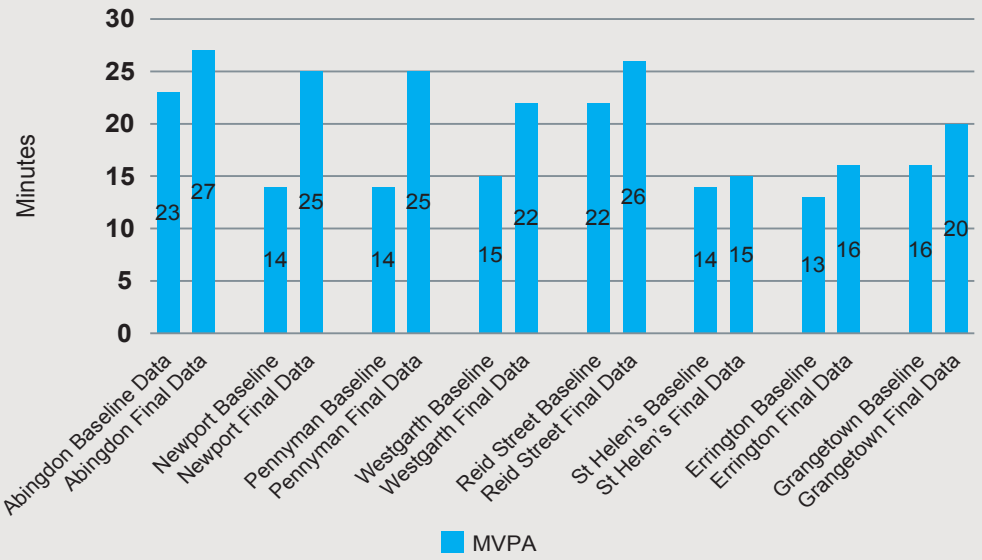
Impact of the Programme

Following the initial pilot, the workstream is now into its third academic year, with a total of **25 schools** engaged in the Redcar, Middlesbrough, and broader Cleveland area, with a **total of 8410 pupils**. **718 staff** have been trained. To support their Sport England expansion work, TVS funded additional schools outside South Tees in Stockton, Darlington, and Hartlepool to participate.

Each school was also provided a pack of 120 child-friendly wearable activity trackers called Moki bands. Using a simple wristband that records steps and active minutes, the bands measure the children's moderate to vigorous physical activity (MVPA) levels and show staff real-life data. The aim was to inspire schools to move more by providing an accurate picture of the children's physical activity levels.

The graphic below shows the MVPA (Moderate to Vigorous Physical Activity) data for eight CAS schools, comparing baseline data to final data when the children wore the MOKI bands. Each school has shown an increase in MVPA from the baseline measurement to the final measurement across the 23/24 academic year. The increases vary among schools, with the highest increases observed at Newport and Pennyman (both showing an increase of 11) and the smallest increase observed at St Helen's (with an increase of 1). This data suggests improvements in physical activity levels across the schools, which is a positive indicator of enhanced physical health and possibly the effectiveness of interventions or programmes implemented to increase physical activity.

MVPA



The increases represent minimums for the improvements observed, as the baseline data may be higher than pre-intervention levels as it is often the first time the children have worn the trackers and are excited to demonstrate how active they are.

Staff were also surveyed regarding their understanding and perceptions around physical activity before commencement and after the school's engagement with CAS was established. The results are shown below. The greatest impacts were in confidence in implementing physical activity within the school, frequency of implementing active lessons and perceptions of the school's value of physical activity.

MEASURE	BEFORE ENGAGEMENT	AFTER INTERVENTION COMMENCED	CHANGE	NOTES
Importance of PA – staff rating the importance of PA at 7 or higher	84%	87%	3%	This positive shift suggests that the project successfully heightened staff awareness of the value of physical activity within the school setting.
Confidence in implementing PA – staff rating confidence of 7 or higher	58%	71%	13%	The data highlights that the project had a significant effect on equipping staff with the skills and assurance needed to integrate physical activity into their teaching practices.
Understanding of the impact of PA on a child's brain – staff rating 7 or above	72%	82%	10%	The rise indicates enhanced knowledge among staff, likely due to the training and educational components of the project.
Understanding PA's link to long-term health – staff rating 7 or above	86%	87%	2%	This modest but meaningful increase suggests that the CAS project contributed to a greater awareness of the health benefits associated with regular physical activity.
Frequency of conducting active lessons (at least once per week).	67%	88%	21%	The data demonstrates that the project had a profound impact on encouraging staff to incorporate physical activity into their daily teaching routines more frequently.
Enjoyment of PA	71%	79%	8%	This suggests that the CAS project not only improved staff attitudes toward physical activity but also made it a more enjoyable and engaging experience for them.
Perceived school support for PA – staff rating 7 or higher	51%	63%	12%	The findings reveal that CAS has positively influenced staff perceptions of their school's commitment to promoting and supporting PA.

The Journey

The initial schools were selected from submitted Expressions of Interest to take part, and they were offered:

- One-to-one support.
- Access to the CAS profiling toolkit.
- A whole school set of MOKI bands.
- Funding via the Dragon's Den project.
- Whole school staff training.
- Networking opportunities.
- Insight & intelligence.

Each school is unique, and for the South Tees pilot to be successful, each had to set up a management committee, self-review their school, select priorities, work at their own pace, and embed changes before moving on. The one-to-one support from RESSP and TVS was tailored to the schools' needs.

Establishing a Management Committee was fundamental as this demonstrated that the entire school was committed and that responsibility wouldn't only be with the PE subject lead. As a minimum, a Senior Leadership Team (SLT) member and a project lead were required to participate. However, what was positive was that others wanted to be involved, including the health and wellbeing lead, PE subject leader, lunchtime supervisors, class teachers, headteachers, deputy head teachers, and school governors.

RESSP and TVS each took responsibility for leading three schools, attending management committee meetings to provide advice, offer challenges, and help drive the pilot forward. During the initial management meeting, the focus was on assessing the schools' strengths and weaknesses and completing the CAS profiling toolkit.

After the review, each school identified three priority areas for development. Following this, RESSP and TVS delivered a staff training session to ensure all staff within each school understood the importance of physical activity and its health benefits, the impact it has on children's well-being, how a lack of it can lead to long-term health conditions and its positive impact on academic performance. Staff were also given the opportunity to review what they were already doing and consider what they could do to improve the physical activity levels of their children.

To effectively change a system, everyone must be involved, but leadership from the management team is essential. Historically, PE, school sports, and physical activity have been primarily directed by the PE subject leader. However, following the training, there was evidence that each management committee was taking the lead and implementing whole-system changes to create a more active environment for children and young people.

During initial conversations, school staff had expressed the belief that most of their children were active for 60 minutes a day. However, following issuing MOKI bands, an analysis of the data revealed that this perception was inaccurate and that children were, on average, only active for 13 minutes daily. It also showed that no children achieved 30 minutes per day. An analysis of a one-hour PE lesson showed only 19 minutes of MVPA. The data served as a wake-up call for staff and senior leaders and reinforced the importance of CAS. Additionally, the Moki bands helped educate the children, and the data motivated them to be more active through friendly competition within classes, year groups, across the school, and among friends. Schools could also measure activity levels before and after implementing new interventions to assess their effectiveness.

> "The active learning CPD has inspired our school to include more physical activity within day-to-day lessons to help engage children, increase attainment and also create a more positive and active learning environment"
>
> *Headteacher of Teesville Primary*

Children have different competence, confidence, and motivation levels regarding physical literacy. Engaging children and young people in the co-design of activities helps to engage them and gives them a sense of ownership. To reinforce this ethos, a Dragon's Den-style event was launched. Each school was asked to educate a group of children on the benefits of physical activity and ask them to design what would make their school more active. Each school was allocated a £5,000 budget for this project.

The children consulted within their school before formulating their ideas. Once they had their proposal, they pitched their ideas to the YGT, RESSP, and TVS dragons at Teesside University. All six schools were successful in their pitches, and funding from YGT was released to each one.

The funding has been used to buy equipment and technology that support more activity in school. One example is the implementation of Amazon Alexa, which is fitted with alarms and installed in each classroom. When the alarm sounds, the class has a physical activity break. Schools have reported that playtimes are more active, and children come back into class more focused and ready to learn.

To reflect the progress schools are making within the system, RESSP introduced ripple effect mapping to demonstrate the changes each one has made; these include:

- Staff training on the benefits of physical activity.
- More active play and lunchtimes.
- Active bursts training and implementation.
- Applying for Opening Schools Facilities funding (DfE) to create more physical activity opportunities outside of curriculum time but on the school site.
- Active lessons.
- Active travel schemes and training.
- Active corridors.
- Development of outdoor spaces.
- Policy changes on PE kit.
- Policy changes on active lessons.

CAS helped identify the interconnecting components of a whole-school adaptive subsystem and exposed the complexity required to create system change. The initial six pilot schools recognised that systemic change takes time. With continued support from RESSP and TVS, they have remained committed and continue identifying and prioritising development areas.

Claire Tennyson, Partnership Manager & Executive Director at RESSP, said, “Working with only six schools allowed us to test and learn the initial CAS framework and gather insight from schools. This insight has been invaluable in helping us contextualise the model for our place.”

“As a result, we have designed a simpler approach, which was met with enthusiastic support from all the headteachers involved.”

“Class activity data continues to be tracked through the Moki bands, and research has been conducted to understand the children’s perception of physical activity to ensure they are enjoying it and are motivated to be active.”

“Additionally, we are surveying staff to gauge perceptions about how much value the school places on physical activity and their confidence in implementing it.”

“Teachers are telling us that children are happier and more engaged when they are physically active. Easterside primary school highlighted that low-level misbehaving, which had been an ongoing problem, stopped the day every child was active for at least 20 minutes”, added Claire.

The original CAS online tool was very comprehensive, but the feedback received was that a simpler model was needed. Schools are short on time, so we knew we needed to make it easier for them to do the right thing. Creating a new self-review tool that is simple and easier to use was well-received by the schools. In addition to the self-review tool, we have also developed a guidance tool. This simpler approach allows schools to take more of a lead in the work and be clearer about how and where it requires external support from partners.

As part of the programme, schools completed a self-review on the whole framework. They then selected three priority areas to develop in their first year of the programme. Across all schools in the first two years, the priority areas included:

Policy: Monitoring and evaluation (4 schools); School improvement plan (2 schools).

Stakeholders: Parents (9 schools); Teachers & school staff (8 schools); Wider stakeholders (4 schools).

School environment: Outdoor space (11 schools); Classroom environment (2 schools); Hall timetable (2 schools); Corridors (1 school); Moveable resources (1 school).

Opportunities: Non-PE Curriculum lessons (6 schools); Active travel (2 schools); PE (2 schools).

Once a school has completed an area of development they were encouraged to select another area of development. At the end of their first year in the programme on average schools made 3.1 areas of improvement.

The insight and learning from CAS has also influenced Active Families, a programme aimed at understanding how families can be supported to be active outside of school and how schools can change their engagement methods with parents. It builds on the early insight that many parents didn’t see a role in enabling their children to be active and considered this the school’s responsibility. A Creating Active Families Officer has been recruited to support the work.

Some the schools have produced videos demonstrating the impact of the work. Here are three examples.

Example 1

Example 2

Example 3

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CASE STUDY

Creating Active and Healthy Places

CREATING ACTIVE AND HEALTHY PLACES

Research has established that built and natural environments significantly determine health outcomes and influence health inequalities. How we plan and design places significantly influences whether individuals can live healthy and happy lives.

Many preventable health conditions are caused by a lack of physical activity, poor diet, and social isolation. These are all highly influenced by the environments in which people live, which in turn are influenced by planning. Planning is a significant part of the system as it also influences other factors, such as opportunities for employment, access to green spaces, housing, transport, and air quality, all of which influence people's health.

Clearly, the built and natural environment have a significant impact on physical activity. As part of our work investigating place-based whole systems approaches to tackling physical activity inequalities, YGT recognised the important role of planning and transport planning in supporting the socio-ecological model's outer policy and physical environment rings. These aspects are recognised as carrying a high weighting in this framework. They are difficult to influence, but the changes once achieved are highly impactful over the medium and long term.

We recognised that if we could influence and contribute to the work that goes into planning and policy decision-making, such as the preservation of green spaces and creation new active travel routes, this would significantly impact people's ability to be physically active.

Both local planning authorities within South Tees recommend that prospective developers complete a health impact assessment (HIA) as part of their proposal. These are to be created in consultation with Public Health, the Planning department, and other stakeholders; but none had been submitted.

Public Health South Tees (PHST) recognised that greatest impact would be achieved by embedding the HIA process within the Local Plan policy regarding health and wellbeing, rather than simply being a recommendation in the supporting text. This thinking resonated with YGT's ambition to influence the built environment to impact population-level change in physical activity. However, influencing Planning departments would require sustained, long-term engagement. PHST had previously identified the departments' impact on wider health determinants but had achieved limited success in establishing collaborative relationships. Previous attempts to enhance collaboration across South Tees had faltered due to a lack of understanding of each other, time constraints, and heavy workloads.

Learning from our work with local communities, we decided to approach the work by first understanding what planners' lives looked like and what it is like to be that person through a physical activity lens. So, rather than approaching building the relationship with a shopping list of tasks, we initially spent a significant amount of time getting to know them and learning what it was really like to be a planner.

Through facilitated meetings, workshops and events, this aspect of the work gathered insight into understanding their workloads, challenges, and priorities, as well as what gets in the way of them doing what they want to do, making progress, trying new things, and taking new approaches.

Utilising YGT's "sludge, budge, and nudge" audit technique, participants from Planning, Transport Planning and Public Health delved deeper into the barriers hindering progress and explored potential solutions. This process revealed issues such as a limited understanding of each other's roles and decision-making processes, as well as a shared passion to creating healthier environments and a strong desire to collaborate.

The assessment revealed that while Planning departments recognised the value of physical activity within their remit, competing priorities, particularly housing demand, took precedence in practice. Over a year, three additional workshop sessions were convened to further explore these issues.

It was identified that YGT and PHST needed to work with Planning rather than at them. Together, everyone agreed that this required focused time and a dedicated resource that sat between Planning, YGT and PHST, and they decided to recruit for this through a new role.

The ability to explore and take a test-and-learn approach to deciding the outcome was significant, as it built trust and strong relationships between everyone involved. Additional expertise was also available through Sport England's planning team, which helped highlight the work's significance.

Sport England also funded the Town & Country Planning Association (TCPA) to support this agenda on a wider scale. They were interested in the collaborative approach and how they could bolster it. Therefore, South Tees also benefited from a new relationship and dedicated TCPA Project and Policy Officer who provided additional knowledge on the planning landscape. Alongside the Royal Town Planning Institute (RTPI), they talked about and advocated for what healthy town planning means nationally and what it could look like locally.

Hence, for the first time in South Tees, the culmination of these efforts brought together senior planners, transport planners, and public health practitioners, supported by Sport England, TCPA, and the RTPI. Despite initial slow progress, participants valued the time for reflection and identified key issues like capacity and staff training.

There was an understanding that colleagues in planning and transport planning recognised the potential benefit of having additional capacity focused on health and physical activity at the intersection of their respective disciplines.

In spring 2023, the initiative sought to establish a planning position with emphasis on physical activity. The recruitment process revealed significant challenges in attracting qualified planners, both for this specialized role and existing vacancies. Recognising the need for a fresh approach, the team pivoted to explore alternative talent acquisition strategies.

The TCPA introduced Public Practice, a not-for-profit organisation that specialises in enhancing the capacity and capability of placemaking teams within the public sector. They draw from diverse built environment disciplines and backgrounds to align an organisation's goals and integrate various perspectives into the planning process. They had a history of recruiting someone into a similar role for Greater Manchester Moving, another Sport England Place Partnership.

Through this route, they successfully recruited for the ‘Creating Active and Healthy Places Lead’ role in public health spatial planning across the South Tees. The ideal candidate was identified when that person applied to the Public Practices Associate programme. Their unique background in architectural practice and research (their disciplinary background is in behavioural science), enabled them to consider how the built environment affects people's behaviour, how behaviour is influenced by the levels of social trust in a neighbourhood, and the extent to which you can change behaviour by raising people’s levels of social trust and the impact it will have on health outcomes. The role presented an opportunity to work at a strategic level and develop policies with potential for significant and generational impact.

The role has been funded by YGT for two years, employed through Middlesbrough Council and line-managed through the PHST team, with direct communication back to YGT’s Programme Director. The desire is that the role will be valued and funded beyond the duration of YGT.

The goal is to enhance collaboration between Public Health and Planning departments in both boroughs to encourage physical activity. This is being accomplished through the Local Plan policy framework, with the aim of creating a built environment that positively impacts health outcomes and supports people to flourish for many years to come.

PHST's vision is to see all local government policies through a health lens, and this role will provide planning colleagues with additional capacity and insight to ensure that all policies can implement this approach.

The role's purpose is to promote and deepen understanding of physical activity and Sport England’s ways of working and how they can integrate into planning and policy decisions. The postholder is also encouraged to go where the energy is and explore other connections to physical activity that may emerge between Councils, PHST, YGT, and their wider network of Ambassadors.

Now in its second year, the role has become an integral link between PHST, YGT, and the respective Council's Planning teams. Significant progress has been achieved across various aspects of the work, resulting in the following key achievements:

- Co-designed and facilitated a Health in Spatial Planning Workshop, leveraging resources from the Office for Health Improvement and Disparities and the sector's best practices. The workshop was initially delivered to local planning colleagues within Middlesbrough Council, with plans to extend it to planning committee members and other stakeholders. Redcar & Cleveland Borough Council colleagues are working with us to implement a similar programme.
- Completed a Health in All Policies (HiAP) assessment of Middlesbrough Council's emerging Local Plan and conducted productive discussions with colleagues in Redcar & Cleveland Borough Council on this agenda, also. These discussions centred on the potential for a similar approach in the future review of their Local Plan with a particular emphasis on childhood obesity.
- In the emerging Local Plan for Middlesbrough Council, the postholder contributed to the Health and Wellbeing Policy and successfully secured an agreement to require Health Impact Assessments (HIAs) for all residential developments that exceed 100 dwellings, and devised an additional HIA screening process, based on health and open space deprivation on a ward-by-ward basis, to be conducted for all major development across the town.
- Facilitated the creation of Middlesbrough Council's first HIA planning toolkit, working with colleagues acrossPublic Health and Spatial Planning, and other stakeholders. The toolkit used the well-respected HIA materials created by John Wilcox and colleagues at Wakefield City Council as its primary model.
- Contributed to PHST Joint Strategic Needs Assessments (JSNA), ensuring integration into Middlesbrough Council's emerging Local Plan's Health and Wellbeing Policy. This work provides prospective developers with clear baseline information about the community and PHST's health and wellbeing goals.
- Collaborated with Natural England on the pilot Health, Wellbeing, Nature, and Sustainability (HWNS) dashboard, which aims to ground the public health equity agenda within a broader planetary health context.
- Contributed to the South Tees Active Hospital programme by examining how the physical environment promotes or inhibits physical activity and individual health across different spatial resolutions.

Looking forward, the focus remains on building existing work, further embedding health and wellbeing into planning policy, and sharing emerging practices with partners across the region and beyond through Sport England's expansion process.

CASE STUDY

PREP-WELL Project Enhances Patient Health Through Innovative Prehabilitation Approach

PREP-WELL PROJECT ENHANCES PATIENT HEALTH THROUGH INNOVATIVE PREHABILITATION APPROACH

Introduction

PREP-WELL was one of four specific Communities of Interest in the original proposal to Sport England from South Tees, building on pilot work undertaken by Professor Gerry Danjoux, Consultant in Anesthesia and Sleep Medicine at South Tees Hospitals NHS Foundation Trust. At its inception, PREP-WELL was the first comprehensive, community-based prehabilitation programme in the UK specifically designed to improve patients' fitness, health, and well-being before they undergo major surgery.

Prehabilitation involves coordinated lifestyle and well-being support for patients in advance of surgery to improve preoperative physical and mental health and speed up recovery.

Inactivity, smoking and excess alcohol all have an independent evidence base for adverse surgical outcomes, and the prevalence of these behaviours in patients presenting for major surgery in South Tees was high and between 30%-50%. Complications following surgery can lead to significant morbidity, resulting in an adverse effect on quality of life and reduced independence.

As an emerging concept, prehabilitation prescribed 'early intervention' physical activity measures to reduce recovery time and, as a result, reduce hospital bed occupancy. It could support multiple behaviour changes, using the "teachable moment" of surgery, across inactivity, smoking, excessive alcohol intake and obesity to generate long-term, sustainable, positive behaviours, as these factors were recognised as broader determinants of physical activity.

Preoperative patients quoted lack of opportunity and concerns around health as reasons for not undertaking physical activity; however, 90% are prepared to undertake physical activity with the proper support. This was identified as an opportunity for healthcare practitioners to support individuals in changing their behaviour positively and permanently.

Impact

PREP-WELL has demonstrated encouraging results, including sustained increases in physical activity, post surgery.

Outcomes with the initial cohort showed that 73% of patients moved from being inactive to achieving a physical activity level recommended by the World Health Organisation (WHO) of 150 minutes of exercise per week plus regular strength training. None of the patients achieved this at the entry. After three months, 63% of patients complied with the WHO aerobic exercise guidance compared to 17% at entry. The team also observed a substantial reduction in other risk factors and improved quality of life. What they found particularly noteworthy was that these benefits were also sustained even three months after surgery. The table below summarises the physical activity and other behavioural changes for the initial cohort.

	ENTRY	EXIT	3MPS	
Patients complying with WHO aerobic exercise guidance (%)	17	75	63	▲▲▲
Patients complying with WHO aerobic + strength training guidance (%)	0	73	29	▲
Mean 6MWD (m)	444	479	N/A	▲
Alcohol >14 u/week (%)	17	13	4	▼▼
Smoking (%)	17	13	17	▶
Anxiety Score (mean) *	5.5	5.4	4.4	▼
Depression Score (mean) **	4.6	3.8	2.5	▼▼
HRQOL (mean) ***	0.54	0.64	0.78	▲▲

* Taken from Hospital Anxiety and Depression Scale (HADS). A higher scrore equates to greater levels of Anxiety (range 0-21).
** Taken from HADS. A higher score equates to greater levels of depression (range 0-21).
*** Taken from EQ5D-3L toll. Score of 1.0 = full health, 0 = a state equivalent to being dead (see Section 10)
WHO - World Health Organisation. WHO guidance = 150 min of moderate exercise and x2 sessions of strength training per week.
6MWD = distance walked in 6 minutes, objective measure of aerobic fitness.

Patient stories collected as part of the feedback and evaluation process:

Patient 1: “I give my fullest thanks for the care and concern you and the team showed me during my time on the programme, and I feel that it helped me in recovery after the operation.

I found it beneficial to my health. It made me feel more positive about the results of my future operation. The exercises and care from the staff increased my confidence as a result.”

Patient 2: “I am so glad and thankful that this programme was available to me. I was telling the lady in the next bed about it as she was amazed at how much I could bend my knee the day after my op. I can strongly recommend this programme, and you do get a fantastic result if you stick to it. I had no strength or bend in my left leg at this point. Within a matter of 10 days of doing the exercises, I got better strength and bend. I was so amazed I even started to do the aerobic exercise. I wasn't one for exercise but I really enjoyed this and got stuck into it. I had my op in August and was home two days later, which was a surprise. Five weeks on and I am walking around the house with no sticks and one stick when I go out. It is hard, but if you keep at it, you will never look back. I am so happy that I have my life back and I’m proud of myself.”

A Health Economist from Newcastle University was also starting to demonstrate how much money the programme could save the hospital, and other evaluation staff were able to evidence the positive impact patients who were physically better prepared for surgery were having on in-patient stays. With a cost of approximately £400 per patient, the programme reduced hospital stays by about two days, translating to savings of over £800 per patient.

Initially delivered face-to-face, the onset of the COVID-19 pandemic shifted delivery to on-line and the development of a digital offer. To date, 495 patients accessed PREP-WELL and 40 iPREP-WELL, the digital offer.

The Journey

PREP-WELL presented a unique opportunity for YGT to work with the team at James Cook University Hospital to expand and embed the presence of physical activity into the PREP-WELL programme and look at changing ways of working within a hospital setting on a large scale. It also meant that working in collaboration, they could shape PREP-WELL’s physical activity offer to become more person-centred and educate health professionals that being active can easily be built into a patient's daily lifestyle and activities.

James Hartley, Programme Officer at YGT, said, “Our aim wasn’t simply to be viewed as a funding source; we wanted to add value by embedding our ways of working and offering consistent support to the programme.”

“Through a collaborative, test-and-learn approach, we worked closely with the team to embrace new insights and foster shared learning. This approach fundamentally helped shift the hospital’s culture, expand their understanding, and recognise that all forms of physical activity and movement are beneficial - not just traditional clinical approaches to physical activity and sport.”

PREP-WELL was designed to run for six to eight weeks for each patient; however, a key advantage of the programme was its flexibility, allowing it to be adapted to accommodate different surgical timeframes and the needs of individual patients.

Each patient participating in the programme had an initial assessment examining their current health and lifestyle risk factors for surgery, and based on their specific requirements, a tailored package was put together. Key components of this included encouraging people to move more and be active, smoking cessation and alcohol reduction support, healthy eating, and mental well-being support. This aspect of the programme was crucial, as the team’s research demonstrated that up to ninety per cent of patients presenting for surgery have at least one lifestyle risk factor for surgery. At the end of the programme, each patient had a follow-up assessment that examined changes in fitness, activity levels, lifestyle, and quality of life.

When the country went into lockdown during the COVID-19 pandemic, the PREP-WELL team was determined to find a way to continue supporting patients, and they quickly implemented home-based exercise options that they could remotely supervise.

A digital prehab programme was created to continue supporting patients in the build-up to surgery. Live virtual exercise classes were also provided to monitor exercise progression and recreate the peer support previously offered through the face-to-face options. Paper-based and audiovisual resources were provided to help patients who could not access the digital offer.

During this time, digital became more critical as it was a vital tool in enabling the prehabilitation service to continue. In addition, the rapid shift from face-to-face interaction to a digital service provided much learning into how patients adapted and adjusted to remote support.

Insight showed that while most people were willing to participate face-to-face, many preferred remotely supervised home-based alternatives because they could do it on their own time and in their surroundings, where they felt more comfortable. These

people would likely have missed out if a digital alternative hadn't been available. The team also learned that patients encounter various barriers when accessing face-to-face support. These include travel difficulties, juggling other weekday commitments, or lack of confidence in a group environment. This learning influenced and shaped the future programme beyond the pandemic.

As a result, a remotely supervised alternative for those unwilling or unable to access face-to-face services alongside an independently aligned digital prehabilitation offer was approved, and the team continued to work closely with YGT to develop the new programme.

Esther Carr, senior physiotherapist and PREP-WELL Project Manager, said: "Implementing a digital prehabilitation offer allowed us to enhance the service we provided to patients and offer a menu of options that gave patients more flexibility and the ability to choose what most suits them".

The digital aspect of the programme, named iPREP-WELL, significantly expanded its reach by enabling effective scaling. The total investment into iPrepwell was £286,757, made up of funding from Sport England - £130,159, MacMillan - £64,500 and South Tees Hospitals NHS Trust - £92,098. The programme's components included:

- A remodelled pathway for patients undergoing higher-risk surgery (including cancer and vascular surgery) enabling more remote support for individuals unable to attend face-to-face classes.
- A pathway to support patients undergoing hip and knee replacements.
- The development and testing of a digital remotely supervised platform to enable access for a wider group of patients.

James Hartley added: "PREP-WELL's innovative approach proved that prescribing physical activity can have life-changing results for people.

"We recognised that being active doesn't need to be delivered by health professionals in a class or a health setting. We educated health professionals to understand that physical activity didn't need to be as prescriptive as all of the other support a patient was getting and that it can easily be built into a person's lifestyle and daily activities."

As PREP-WELL approached the end of its four-year funding investment from YGT, the team could evidence that it would save money in the longer term, although it still needed some investment from the hospital to continue.

We were naturally disappointed to learn that the hospital trust was unable to provide additional funding for the continuation of PREP-WELL's face-to-face delivery, particularly after the significant effort the PREP-WELL staff invested in developing a business case to sustain it. However, digital prehabilitation interventions offer scalability, and iPREP-WELL has continued to be delivered in South Tees. Training has been designed to enable healthcare professionals to promote, support, and facilitate intervention delivery in this format as part of routine clinical care.

Alongside the trust's decision, the NHS North East and North Cumbria Integrated Care Board (ICB), in collaboration with partners across primary and secondary care, local councils, and the voluntary, community, and social enterprise sector (VCSE), announced that eight areas would receive funding to deliver a programme of support for patients awaiting non-urgent surgery, including South Tees. The programme, 'Waiting Well' also aims to tackle health inequalities, so it has adopted a targeted approach to identifying patients at risk of experiencing health inequalities with long-term health conditions. It aimed to engage with patients, support them in adopting healthier lifestyles while waiting for surgery, prepare them for surgery and recovery, and inspire patients to continue their healthier lifestyle choices in the long term.

Waiting Well presented many immediate similarities to PREP-WELL's way of working, and the team who had worked on it alongside YGT recognised they were perfectly positioned to support this and extend their learning across the region. Fleet-footed, they embraced the opportunity to bring the previous work front and centre, transfer the learning to become part of Waiting Well and speak confidently to a much wider range of health professionals about how physical activity can be embedded into this way of working.

As a result of their ongoing involvement in Waiting Well, Professor Gerry Danjoux and Esther Carr continue to build upon their PREP-WELL experience, communicate their learning, support others in changing the system, and to value physical activity.

The lasting impact of the YGT approach to the PREP-WELL work means that the insight, learning, and lived experience of delivering an innovative approach to a community-based prehabilitation programme have influenced the delivery of Waiting Well and supported 458 patients so far. This extends to a significantly larger geographical area and will positively impact the next phase of Sport England's expansion work into new areas across the North East and Cumbria.

Mark Fishpool, YGT Programme Director, said, "Building collaborative relationships and delivering multi-stakeholder programmes take time, but by listening to patients and taking a person-centred approach, we were incredibly successful at embedding physical activity into the PREP-WELL prehabilitation programme.

“Through this work, we are now actively participating in and influencing Waiting Well steering meetings, which means many more patients value the benefits of physical activity before and after they undergo surgery.”

Key insights from PREP-WELL

In phase one, during the COVID-19 pandemic, approximately one-third of patients wanted a home-based programme. Of the people wanting this type of programme, there was a 50/50 split between those wishing to access this digitally vs paper-based.

Despite undergoing major surgery, COVID-19 enforcing a period of isolation, and the programme delivery moving to a virtual platform, a reduction in inactivity of nearly 10% was observed. This suggests the potential for longer-term behaviour changes in participating patients.

One size doesn’t fit all. Through the development of PREP-WELL, we learned that offering a menu of options to patients helps with engagement and patient satisfaction. We took this insight and learning into developing the Waiting Well Programme.

Supporting patients in addressing their personal barriers to engagement improves engagement. Working across sectors with Waiting Well, alongside social prescribers and a Health and Wellbeing Coach, has enabled further enhancement of the service provided to patients.

Engaging in a pre-operative health and wellbeing programme has benefits that can be seen on an individual patient level, and it also benefits the system as a whole.

Reflections and Learning

Within the hospital, PREP-WELL had the backing of many highly qualified surgical champions who believed in the work's positive impact. This support was perceived as a credible way to support the programme continuing beyond the YGT funding through the trust’s own investment.

On reflection, throughout the programme, communicating and influencing those within the hospital trust responsible for budgets and investment decision-making would have been merited. As the work moves into Deepening and Expansion, we need to engage and influence the most senior leaders if we want to change policy and behaviour.

Also, if the PREP-WELL team had taken a more collaborative approach to communicating the impact and learning to the trust with the support of other people, e.g., the Director of Public Health South Tees/Programme Director of YGT, and presented the programme's pioneering influence that enabled them to work with NHS England, The Care Commission, and NHS Horizons, would the trust's decision have been different?

Both of these reflections highlighted for the YGT team the importance of communication throughout the entire programme journey to educate and influence at many levels. A strategic approach to who should be communicated to, when, and how should have formed part of the programme.

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CASE STUDY

Helping people living with chronic pain to become active

HELPING PEOPLE LIVING WITH CHRONIC PAIN TO BECOME ACTIVE

Flippin' Pain™ is a public health initiative that brings the science of pain to people who need it in the places they live and work, in the heart of their communities. Championed by community healthcare services provider Connect Health, it aims to change (or flip) how people think about, talk about and treat persistent pain while raising awareness of the problem of pain. Flippin' Pain believes that empowering individuals and communities affected by persistent pain through education and understanding is key to transforming the approach to pain on a systemic level.

Persistent pain affects 30-50% of people in the UK. Its impact is significant, negatively affecting physical and mental health, social and home lives and people's ability to stay in work. Chronic pain is more prevalent in the North East than in any other part of England; it is thought to affect around 43% of people, and opioid prescription rates in the area are 300% higher than in London.

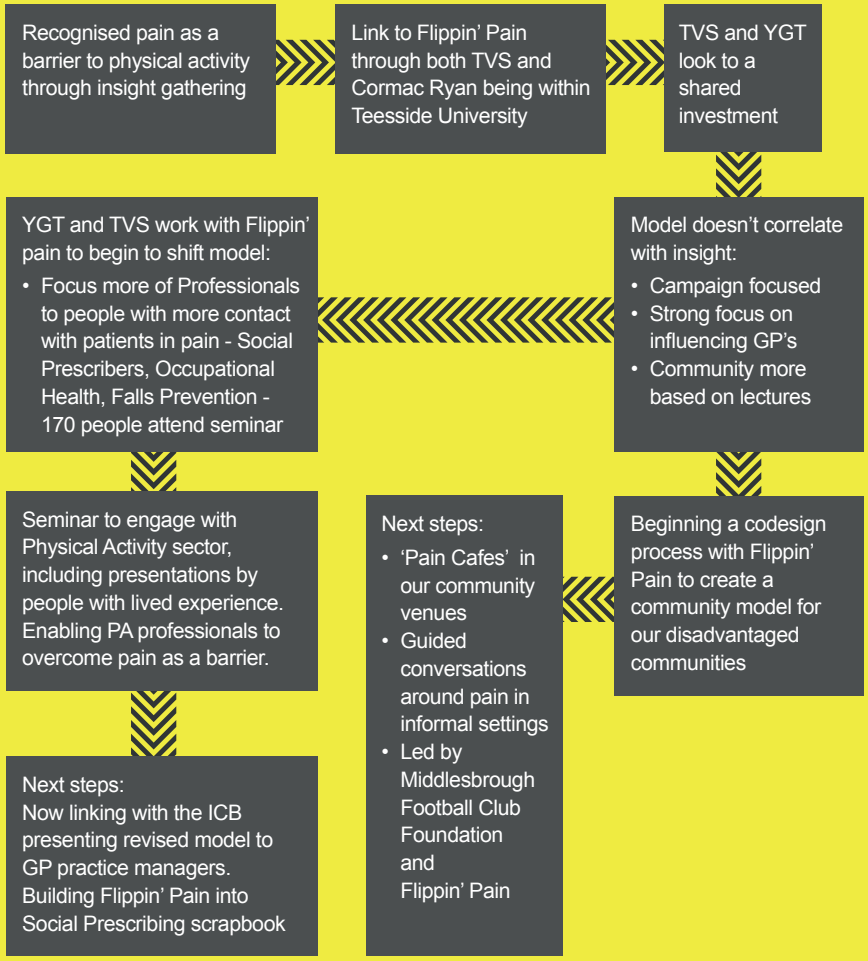
Through insight from health professionals and patients, YGT and Tees Valley Sport (TVS) identified pain as a significant barrier to physical activity but had not yet found a way to tackle this issue. After attending a local seminar where Cormac Ryan, Professor of Clinical Rehabilitation at Teesside University and a community pain champion for Flippin' Pain™, spoke, they realised that forming a partnership could be an effective solution.

This has led to a two year journey to reimagine pain and physical activity, which is summarised in the graphic to the right.

Together, they collaborated with Flippin' Pain™ to share insight and address pain-related health inequalities. At this time, Flippin' Pain™ was delivering events within Teesside University, and health professional sessions focused specifically on GPs. From our insight, we argued that offering public sessions in local communities and expanding outreach to nurses, social prescribers, and other health practitioners would create a more significant impact.

This initial coming together led to YGT and TVS joining a steering group. Throughout these sessions, they were able to share valuable insight and learning to nudge the Flippin' Pain™ team to do things differently.

OUR JOURNEY UNDERSTANDING PAIN



As a result of this initial groundwork, a first-of-its-kind public and private sector collaboration was forged to tackle the issue of pain head-on. It aimed to directly reach those living with chronic pain, overcome barriers to physical exercise, and challenge outdated perceptions and beliefs relating to pain management and treatment.

Carol Appleton, Programme Support Officer for You've Got This, said: "Through our work in the local community, we know that many people live in pain, which prevents them from being active. They often believe they can't do anything about it because they have never been told or shown they can."

> "By helping health professionals and those living in pain change their perspectives and flip how they deal with pain, we can help people to live more active lives."
>
> *Carol Appleton, YGT*

Together, Connect Health, NHS North East and North Cumbria Integrated Care Board (Including North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust), YGT, TVS and Teesside University, pooled resources and expertise, to co-create and deliver a series of targeted events and activities for the public and health professionals.

These included the Flippin' Pain™ Tees Valley Outreach Tour. It comprised 19 events held over six days, featuring educational workshops, public seminars and experiential pop-ups. 2,400 people engaged, and more than 725 people joined the sessions, which were led by a team of pain professionals, educators and community champions. This was backed up with a suite of interactive multimedia learning resources that brought the six key messages to life through podcasts, infographics, and animations. These resources were co-created by a team of pain experts, including people with lived experience of persistent pain.

A key insight from YGT's work was that many professionals were supporting people living with chronic pain, as well as GPs. The thinking behind targeting this wider audience was that these health professionals have more time and contact to try and change their clients' behaviours to be more active while still living in pain; whereas a GP only has an 8-minute window. 'When PAIN gets in the way' educational sessions were codesigned for those professionals supporting people with pain or promoting active lifestyles. As a result, 170 social prescribers, nurses, occupational health, and falls prevention nurses attended the events.

Through working with YGT and TVS, Flippin' Pain has also built a relationship with the North East and North Cumbria ICB. Together, they have connected Waiting Well and work independently to explore how pain pathways, physical activity, and movement can permeate all areas of the hospital.

YGT's approach to the Flippin' Pain initiative is a significant example of fostering a trusted collaboration through distributed leadership. While they continue to play a role in the project, they are no longer the primary drivers for changing their ways of working. Instead, they are becoming deeply embedded in the processes, ensuring sustainability and long-term success.

Having adapted the original communication approach from events at Teesside University, flipping it, and taking the initiative out into the community, it has been easier for people to access the information. Often overlooked, the location of a venue can be a significant barrier for individuals in hard-to-reach communities. The team recognised that when working in areas of deprivation and people living with high levels of pain, they are going to have to adapt the communication to be able to reach them. Building on this insight, we are now exploring the introduction of HOPE (Helping One-another with Pain Education), facilitated community support sessions in accessible and familiar spaces in deprived communities to connect with people where there are high levels of long-term conditions and inactivity.

We are especially proud of the fact that they have been able to amplify the synergy between pain and physical activity. Previously, it felt disjointed and only rooted in pain and psychology. Because YGT commissioned the work, we were able to shift the narrative onto getting people to move and re-educating them to recognise that it's not just about living better with pain; it's about living better and being active with pain. This shift is especially crucial given that 44% of people who report being inactive cite pain as the primary barrier. It has also enabled the team to reposition their campaign to focus on both pain and movement rather than pain alone.

The project's initial phase evolved into a series of events tailored for physical activity professionals. A two-day event focused on education, helping attendees reframe their understanding of pain and providing practical tools to integrate this knowledge into their work. This has fostered a seamless collaboration between healthcare and physical activity professionals, ensuring that both groups recognise that pain doesn't have to be a barrier to activity and that hurt doesn't always mean harm.

The collaboration has been an award-winning success. At the HSJ Partnership Awards 2024, the Flippin' Pain™ partnership was officially named the "Gold" winner of the Most Impactful Partnership in Preventative Healthcare.

Flippin' Pain™ also won a Bright Ideas in Health Award in the Innovation in Clinical Education category. The regional awards celebrate the achievements of individuals and teams in the North East working within the NHS, industry, and academia who have improved patient services through technical innovation or better service delivery.

Insights and learning:

Changing Flippin Pain's perspective about who they should communicate with, from GPs and GP consultants to a much wider group of health professionals, has significantly impacted the work's effectiveness.

YGT is also including information about Flippin Pain in a new social prescriber scrapbook that they are developing in collaboration with social prescribers across Redcar & Cleveland.

A recent large-scale study conducted by the Richmond Group of Charities explored the barriers to physical activity for individuals with long-term conditions. The research found that health professionals often attributed these barriers to factors like a lack of motivation, money, time, capacity, or skills. In contrast, patients identified chronic pain as the primary obstacle, with many stating that pain itself was the biggest barrier to activity. This contrast underscores a significant empathy gap between those living with long-term conditions and the professionals supporting them. Over the past two years, this initiative has substantially addressed that gap. By sharing insights, fostering mutual learning, and upskilling professionals and patients, the programme is better equipped to support individuals in managing their conditions. Additionally, it provides high-quality, practical resources and training to enhance care and promote more effective, empathetic support.

The key impacts of the work to date can be found here (link).