Better Care Fund 2025-26 HWB submission

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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

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

DRAFT

- 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

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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.

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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.

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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.

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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.

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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.

<u>UCR and Hospital@Home</u>

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.

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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.

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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.

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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%	

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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.

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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.

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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.

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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.

DRAFT