Health and Wellbeing Board

Middlesbrough
(Live Well South Tees Board)

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

How have you gone about involving these stakeholders?

Our BCF plans have been developed collectively over the past years through regular meetings between CCG and Local Authority commissioners, Pooled Fund managers and BCF leads. It has been agreed that many of the BCF schemes are recurrent 'business as usual' so these will be included in the plan for this and future years.

Linking with the members of these groups, colleagues across the system have the opportunity to present business cases around potential new schemes to address a need or gap identified and which would support the BCF and system priorities and metrics. These are duly considered against what uncommitted funding is available and decisions on whether to approve them are made jointly between the CCG and Local Authority.

In South Tees (Middlesbrough and Redcar & Cleveland) many of our new schemes this year have been developed to support the Home First/Discharge agenda. This has involved extensive discussions and planning with colleagues in South Tees Hospitals NHS Foundation Trust as well as local Voluntary Development Agencies.

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

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

Executive Summary

This should include:

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

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

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

Our ICP objectives are:

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

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

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

BCF Metrics:

Avoidable Admissions

There is a continued priority on admission avoidance in urgent care situations focussed on ensuring robust assessment, decision making and diversion to more appropriate services and support when needed. There are a range of services funded by the BCF to support this, for example additional rapid response, front of house services in the Acute Hospital, including a Frailty Co-ordination team, prevention initiatives and our Single Point of Access. These will be complemented by the urgent community response team which is being implemented through the use of Ageing Well funding (see below).

Length of Stay and Discharge to Normal Place of Residence

This has been a focus of joint initiatives and plans this year and most of the changes to our BCF plan this year are to support these outcomes. Please see the Supporting Discharge section below for details and also this embedded update provided by colleagues at South Tees Hospitals NHS Foundation Trust:

STHFT Update for BCF Plans.docx

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

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

Effectiveness of reablement - *proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)*
The range of BCF schemes to support reablement will continue and include assistive technology, rapid response, an expanded reablement team and overnight planned care.

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

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

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

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

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

Ageing Well priorities:

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

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

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

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

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

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

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

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

Governance

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

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

Tees Valley CCG BCF Goverance Overview.p

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

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

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

Overall approach to integration

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

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

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

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

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

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

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

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

Supporting Discharge (national condition four)

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

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

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

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

The shift to a 'Home First' approach means that discharge planning starts on admission with daily clinically led review that uses the criteria to reside ensuring that anyone remaining in an acute bed meets one of these 11 criteria and where they no longer meet the criteria they are discharged as soon as possible the same day or the following day.

The ICP has established surge meetings which are flexed (stood up/down) based on pressures and need. Meetings have been closely linked with place based discharge groups to ensure patients were discharged and placed on the next stage of their pathway of care, maintain flow throughout the hospital and promote rapid and supported discharge from hospital to the most appropriate place for recovery in a planned manner rather than an extended length of stay in an acute hospital bed

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

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

Home First Strategy

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

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

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

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

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

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

<u>Workforce Pressures:</u>

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

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

Plans from April 2022:

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

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

Disabled Facilities Grant (DFG) and wider services

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

Middlesbrough Council, as the Housing Authority, developed a number of policies in line with the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to assist residents of Middlesbrough who are disabled or who have a long term health condition to live independently and to carry out essential day-to-day activities. Specifically, it sets out the principles that will be applied in relation to the provision of adaptations, equipment and repairs to prevent the need for Social Care, hospital intervention and to enable a person to continue living independently, comfortably and safely in their own home.

To meet our statutory duty, our priority is to ensure that sufficient funding is allocated to our Disabled Facilities Grants programme however, we have had the flexibility to introduce services which are more reflective to support delayed transfers of care and readmissions to hospital. These include:

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

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

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

Equality and health inequalities.

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

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

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

There is a local approach to person centred care working together in order to make best use of existing expertise, capacity and potential of people, families and communities. We are working across four main groups of people, who typically have high levels of need, across health and social care:
•Children and young people with complex needs, including those eligible for education, health and care (EHC) plans
• Older people with frailty and or/with multiple long-term conditions
•People with learning disabilities with high support needs, including those who are in institutional settings or at risk of being placed in these settings
•People with significant mental health needs, or those who use high levels of unplanned care.

We will work with the Ageing Well programme, to ensure Personalised Care approaches are fully embedded to support healthy ageing across the life course, as well as within the programme specific workstreams (Anticipatory Care, Urgent Community Response and Enhanced Health in Care Homes) and workforce competencies.

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

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