This document was classified as: OFFICIAL

BCF Narrative 2023-25
Darlington Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing 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 ICB (Integrated Care Board) 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 ICB and Local Authority.

The governance structure supporting the BCF decision making process is made up of the following:

- Darlington BCF Delivery Group: with representatives from the local authority and ICB commissioners, operational and finance leads, the group are responsible for making recommendations on new business case requests as well as reporting on performance against the metrics of the programme
- Darlington Pooled Budget Partnership Board: Consider all recommendations from the delivery group confirming all business cases deliver against the metrics of the programme as well as providing challenge to decisions made. Membership is made up of senior executives across LAs and ICBs
- Darlington ICB provides system wide assurance to HWBB on programme performance as well as recommending solutions for any areas of escalation
- HWBB: Has oversight and ownership of the programme, approving all returns and programme plans

Throughout the lifetime of the BCF Programmes, there are a number of operational working groups in place, each with a focus on key areas of the programme. These include Enhanced Health in Care Homes; Frailty pathways and Discharge Planning. These groups include representation from NHS, social care, PCNs, TEWV and the voluntary sector.

Many of our new schemes this year have been developed to support the Hospital Discharge agenda. This has involved extensive discussions and planning with colleagues from County Durham and Darlington NHS Foundation Trust and other partners for example the care home and domiciliary care sector. The LA, ICB and Foundation Trust engage regularly with the care home and domiciliary care sector via forums and other mechanisms to identify needs, pressures and provide support.

As Darlington’s Health and Social Care System recovers from the Covid 19 Emergency pandemic, the Council is currently refreshing its approach to housing need within the Borough. This comprises of review and gap analysis of key strategic and operational priority areas:

- Review and further development of the Housing Needs Assessment including supported living accommodation; extra care, sheltered housing , private rented and social housing sectors. Of particular importance in the current cost of living acute pressure is the application of the recent Homeless legislation. An impact assessment will be conducted in the changes to Section 21 legislation (currently before Parliament) especially with regard to the affordable social housing sector. The review will be considering impact on the default to home model in discharge pathways and is supported by the North East ADASS Commissioning Network.
- The Council has commissioned services with supported living local providers arrange of preventative and first response services including Homeless Hostel; Outreach services, Multi – agency begging support and accommodation/ support services funded through the Domestic Abuse Act (2021) for people in crisis.
- Operationally, the local health and social care response to housing need is to continue to support as many people to live as independently as possible in their own homes through the Disabled Facilities Grant (DFG) . In addition, at the of "point of admission" housing related liaison with clinical staff within inpatient acute settings is identified e.g., Darlington such as Westpark Hospital (primary mental health needs) and County Durham and Darlington Foundation Trust's Darlington Memorial Hospital to ensure compliance with Homelessness "priority" need and advice and support for those inpatients deemed to be at risk of homelessness.

Executive Summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan

The priorities of both the North East and North Cumbria (NENC) Health and Care Partnership strategy and the developing collective Tees Valley Place Plan, include aims and programmes to improve the quality of life for people through admission avoidance and investment in preventative services and tackling delays in discharges with improved outcomes.

Our partnership priorities include:

- Strengthening the provision of Home Care and Extra Care Housing and reducing the reliance on residential and nursing homes
- Working with the care market to increase capacity and sustainability
- Reducing the time people spend in hospital whose needs could be better met by access to social care
- Developing shared solutions around housing and maximise the use of digital technology
- Working to identify and support more people who are providing unpaid care
- Improving joint discharge processes between health and social care
- Scaling up intermediate care across all of our places and reducing the reliance on beds
- Upskilling and scaling-up of social care staff and services across all of our places, enabling them to respond to the needs of local people and ensuring social care staff are valued as equals within the health and care system

- ➢ Expand the range and uptake of 2 hour community response service to enable people to receive timely care in the right place

Our Better Care Fund plan supports the local and regional aims and outcomes. Our priorities for 2022-23 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.

In summary the key changes to our previous BCF plan include:

- Reconfiguration of care home and planned/unplanned community health teams
- A dedicated iSPA for D2A/hospital discharges, intermediate care and unplanned care which continues to be developed
- EHiCH and COVID has resulted in a drive to improve access to support and advice for care home residents and has provided:
    - Improvement in take up of NHS Mail
    - Programme of work for medication management and proxy ordering
    - Consistent approach to delivery of DES for older peoples care homes

The key changes to our plan this year will be the use of the BCF and Additional Discharge Funding to continue initiatives that support discharges to the right place with the right care. Our aim is particularly to reduce the reliance on use of beds and to promote an enhanced reablement model to enable more people to be discharged on pathway 1 with rehabilitation and reablement to optimise the chance of recovery.

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 BCF Governance Overview

We have monthly meetings of the BCF Delivery Group which is formed of commissioning, finance and BCF leads from the Local Authority and ICB. This Group collectively plans, reviews new business cases, and monitors expenditure of the Better Care Fund.

The Pooled Budget Partnership Board receives recommendations from the BCF Delivery Group. The Board has senior membership from the Local Authority and the ICB and its role is to:

- Provide strategic direction on the Individual Schemes
- Receive financial and activity information
- Review the operation of this Agreement and performance manage the individual schemes
- Agree such variations to the s75 Agreement from time to time as its thinks fit
- Review and agree annually revised Schedules as necessary
- Request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Pooled Fund
- Manage the performance of the Better Care Fund in line with the key performance indicators agreed nationally
- Review and agree annually a risk assessment and a Performance Payment protocol
- Receive and approve business cases for proposals against the pooled budget

In addition to the above the Health and Housing Scrutiny panel consider all BCF returns and plans prior to any submission and consideration to HWBB. This ensures all system partners, including housing colleagues, can challenge the programme and schemes within.

New governance arrangements at place are being finalised by the ICB. Moving forwards some aspects of BCF planning and implementation may sit within the Place Committee.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- *Joint priorities for 2023-25*
- *Approaches to joint/collaborative commissioning*
- *How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.*

Joint priorities for 2023-25 will be driven by ever increasing presentation of complex needs of older people in a post covid pandemic environment. The post Covid pandemic operating environment brings with it the associated increased risk of hospitalisation and increasing length of stay, future nursing home admission and mortality.

The ICB, Darlington's Adults Joint Commissioning Board, County Durham and Darlington NHS Foundation Trust, Tees, Esk and Wear Valleys Trust and VCSE will be informed and guided by both national and local policy to address this challenge across health and social care. They will, as in previous years, take into account the NHS Long term Plan, Regional ICB planning, local HWBB strategies and the Better Care Fund plans.

The agreed strategic aims and objectives of the Joint Commissioning Board (Adults) for Darlington are to:

- improve outcomes for adults and older people through achieving best value, economies of scale and improved efficiencies or co-ordination in the joint planning/commissioning of services
- improve joint planning and commissioning activity with regard to services for

adults and older people
- map existing services and identify opportunities to remove duplications, identify gaps, and explore opportunities to align or pool budgets
- agree priorities for joint planning and commissioning based on needs assessments and available evidence base
- ensure effective delivery and monitoring of jointly commissioned services and co-ordinate development of joint commissioning strategies
- support the development of provider services within the area to meet identified needs
- consider horizon scanning and to understand the policy implications of new national policies in respect of children and young people, influencing local policy direction implementation
- establish task and finish groups as and when required in order to take forward specific pieces of work.

Joint priorities for 2023-25 are:

- Maintain independence at home/ place of residence and prevent hospital admissions where possible
- Review and enhance the intermediate care and reablement offer in Darlington to restore patients' (and associated family carers support) confidence re- integration back into community
- Ensure that clear and effective integrated discharge pathways are developed and adopted across acute and community services
- To ensure timely assessment of discharge requirements and ensure that the flow from the acute system into community services is sustained
- Digitisation and improve health and wellbeing of people living in care homes using digital technology in accordance with TV Care Homes digital strategy
- Improve coordination of care for people presenting with multi- morbidities

iBCF Funding

As part of the template submission, schemes 61-68 detail the allocations across the iBCF Programme. As part of the conditions of the funding, these schemes continue to address the following:

- Meeting adult social care needs
- Reducing pressures on the NHS
- Supporting more people to be discharged from hospital
- Ensuring that the social care market is supported.

National Condition 2

Use this section to describe how your area will meet BCF Objective 1: ***Enabling people to stay well, safe and independent at home for longer***

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- *Steps to personalise care and delivery asset based approaches*
- *Implementing joined up approaches to population health management and proactive care and how the schemes delivered through the BCF will support these approaches*
- *Multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake*
- *How work to support unpaid carers and deliver housing adaptations will support this objective – LA to expand*

Enable people to stay well, safe and independent at home for longer:

A key system aim across the Tees Valley is to continue to identify appropriate alternatives to a hospital admission through the use of more innovative service models and by better joining up the service offers available across primary, community and secondary care; including NHS 111 and our Ambulance Service provider.

We know from national and local evidence, and via the Fuller report, that people's care needs can often be best met outside of a hospital setting through integrated (neighbourhood) teams, where admissions can be avoided with the right care and support in place. We are stepping up capacity for out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, and in some cases, replace the need for admission, and in others facilitate people being able to safely leave hospital sooner.

Across the Tees Valley we have already commenced and made great progress in the development and implementation of our **Virtual Ward** models. We now need to extend and accelerate the breadth of conditions and patients who can be supported, out of hospital, using this approach. Our Virtual Wards aim to provide our patient population with hospital standard care within their own home, helping us to:

- Prevent unplanned hospital admissions and delays in hospital discharges
- Further reduce inequalities for people by ensuring all health and care needs are met through delivery of virtual frailty ward and virtual respiratory wards
- Embed good commissioning practices in integrated health and social care
- Improve outcomes and experiences for people admitted into the virtual wards
- Make data and evidence the basis for policy development, good practice, and targeted improvement support

Urgent community response (UCR) is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care within two-hours and/or reablement care responses within two-days. They provide a person-centred approach to optimise independence and confidence, enable recovery and prevent a decline in functional ability. Services should adopt a 'no wrong door' ethos and work flexibly based on need, not diagnosis/condition.

Our Urgent Community Response (2-hour UCR) aims to provide urgent care to people in their 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:

- ✓ reduce the risk of deconditioning, delirium and hospital-acquired infection
- ✓ improve hospital flow
- ✓ support older people to regain independence
- ✓ reduce 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.

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 community services funded by the BCF to support this including: A rapid response domiciliary care service commissioned to provide a 2-hour response and overnight sitting if required and a responsive integrated assessment care team (RIACT) which offers crisis response alongside community nursing services.

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. They 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.

Ageing Well priorities:

Urgent 2 hour community response:
Existing BCF funded services which support this include RIACT and community nursing working together 7 days a week to support the triage and response to urgent referrals from the community. In 2021 the services have also been reconfigured to become a planned and unplanned team, offering a dedicated care home response and also an urgent community response.

Darlington Borough Council are part of the 'Urgent and Emergency Care Managed Clinical Network' and local 'Tees Valley Urgent Community Response Group.' Proposals have been put forward to the group via the Ageing Well monies to fund:

- Additional staff to improve the community crisis response and enhance the service cover and deliver full triage options as part of the iSPA for Darlington from 08:00 to 21:00 seven days per week.
- Continuation of the “Making Space” Rapid Response service in Darlington which provides an 8a.m. to 8 p.m.- 7 days per week domiciliary care service and supports the effective discharge flow from the RIACT team into community provision. The Rapid Response service is an essential element in the D2A - default discharge to a person’s own home and provides an emergency response/ crisis intervention and aims to move on clients within 48- hours of discharge. The service is aligned with the ethos of the urgent community response initiative by promoting

faster recovery from illness or injury and the facilitation of safe and timely discharge from hospital. It also prevents unnecessary admissions into Hospital.

- Additional Therapy input into the Darlington Care Home Team. Patients who reside within care homes do not always receive the same level of therapy input into maintaining their present levels of independence or functionality. Working with the CDDFT Care home Team and Primary Healthcare Darlington (PHD) to focus on the enhanced Healthcare in Care Homes (EHiCH) the proposed increase of therapy input in day-to-day activities enhancing the lives of patients and residents in care homes, including spot beds. Delivering increased skills and knowledge across care home workforce.

  By offering targeted therapy input into the already successful Care home focused teams will support patients and the care home workforce deliver sustained independence and functionality and slow the progression of supported living/residential care patients declining into dependant nursing care.

The proposals will impact and deliver the following;

- Meet the UCR standard for urgent community response services to be available 7 days a week 8 to 8 and 2-day reablement standard.
- See an increase in the community workforce numbers to deliver the Ageing Well UCR standards
- Improve discharges from hospital through a the 'home first' principles
- Reduce pressures on Emergency and Urgent Care Centres
- Reduce or stem growth in non-elective admissions
- Improve the quality-of-care planning and functional presentation of people living in care homes
- Reduce or delay the requirement for people moving from 24-hour residential care into 24-hour nursing care
- Reduction in the number of falls in care homes
- Reduction in care home admissions
- Reduction in ongoing need for care following reablement support
- The community data set for UCR

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. Prior to the DES, community nurses were reconfigured to provide reactive care to care homes with a 'virtual ward round' response from GPs to support clinical decision making and care planning. As part of the DES home round, community matrons undertake a proactive home round and have monthly multi-disciplinary teams with GP, pharmacy and nursing input as a minimal to support personalised care planning, alongside the care home nursing team.

Dedicated pharmacy support has been commissioned to drive quality regarding medicine management, policies and the implementation of proxy medication ordering for all care homes.

A digital programme of support has been commissioned to enhance and support the delivery of digital developments in care homes to support delivery of:

- NHS Mail
- Proxy ordering of medication
- Personalised care and support planning
- Information sharing

Anticipatory Care

Many of our BCF schemes support the delivery of proactive care and support, particularly older people living with frailty to help them stay independent and healthy for as long as possible at home (or the place they call home).

Over the coming months our collective system including community health teams, Primary Care Networks, social care, mental health teams, community pharmacy, the housing and voluntary sector will be establishing or building on multi-disciplinary teams to strengthen relationships where required, delivering Anticipatory Care to an identified cohort of individuals. A key outcome will be that services will be transformed from being crisis driven to working in an integrated, personalised, and co-ordinated way for patients.

Priorities for this year and early 23/24 are:

- The development of clear ambitions for Anticipatory Care across the Tees Valley, working closely with providers and more specifically, PCNs to translate these ambitions into a comprehensive Anticipatory Care Plan
- To identify key segments of PCN's registered practice populations using risk stratification tools, who have complex needs and are at high risk of unwarranted health outcomes. Once this baseline/cohort has been developed, agree the number of individuals to be offered Anticipatory Care in 23/24
- To clinically validate individuals as appropriate for Anticipatory Care, prioritising those with greatest clinical need first
- To implement a holistic assessment process to understand the goals and ambitions of those identified as the Anticipatory Care cohort

The ICB aims to ensure as part of service re-design, that the key principles of personalisation are considered and embedded into new pathways including personalised care support plans, Shared Decision Making and Patient Activation Measures (PAM). Knowledge and opportunities will be shared across all Tees Valley place portfolio teams

National Condition 2 (cont'd)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- Learning from 2022-23 such as
  - Where number of referrals did and did not meet expectations
  - Unmet demand, ie where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - Patterns of referrals and impact of work to reduce demand on bedded services – eg admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services

- Approach to estimating demand, assumptions made and gaps in provision identified
  - Where if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

- How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans

Darlington Discharge Pathways
In Darlington, the overarching aim is to support people in the community and when a person is admitted and discharged from hospital, to get them back to their usual place of residence, reflecting the Hospital Discharge and Community Support Policy and our 'Home First' ethos.
In almost all cases the short-term intermediate care services/ staff who support people to remain in the community (step-up) and support people following discharge (step-down) are part of the same service/ staffing cohort. This is the case for domiciliary/ home-based care and bed-based care with the intermediate care beds also being used for both step-up and step-down. Generally, there isn't dedicated step-up or step-down staffing/ capacity (including beds) rather usage is based on demand. However, the vast majority of the short-term intermediate care demand (home and bed-based is following a discharge from hospital.
People going home with little to no support needs (Pathway 0) make up the largest proportion of discharges. There are several services available to support people with low level support needs. Alongside these commissioned services, there are some charitable services who will support people with day-to-day activities. These services are ad-hoc and no formal commissioning or monitoring arrangements are in place.
Depending on the level of need, there are services available to people being discharged on Pathway 1, who need a little more help to recover at home. This includes Domiciliary Care Providers and the Trust Rehabilitation Team who provide up to 4 weeks of support at home. Alongside these we also have a Home First service and Telecare Service and some condition specific healthcare services i.e. Community Respiratory Service.
We have a range of community beds which can be used for both step-up and step-down. In terms of Pathway 2 and 3 discharges there's no distinction to the way the beds are commissioned, and they can be used for either Pathway until the capacity has been used.
There are 23 beds available in Rydal Care Home, which is the core intermediate care facility commissioned on a recurring basis. 14 of these beds are commissioned as Rehabilitation beds and 9 as Nursing beds, however there is an option to flex as needed and there is now a less obvious split in the way the beds are used. In addition to this there is an option to use spot purchase beds when Rydal beds are not available. The availability of spot purchase beds is dependent on a number of factors, including the local care home market, the needs of the individual, the wraparound supporting workforce and funding restrictions.

We have utilised some of the additional discharge funding to increase the capacity for spot purchases in 2023/24 to approximately 10 per month as a result of increased demand. This is shown equally in the capacity section of the planning template, however there will be times of low demand and time of surge, particularly over winter, and the beds can be flexed (increased) each month as a result of the spot purchase contracting arrangement.

2022/23 Learning Points
Completing the capacity and demand requirements in 2022/23 formalised a process which has been taking place in Darlington since the COVID pandemic. Representatives from Adult Social Care and Health services work together and collaborate via a weekly meeting and have regular meetings with the BCF Delivery group to explore pressures, agree resolutions and plan how best to cope with demand and capacity, this ensures the flow of patients continues despite any arising challenges. In times of high demand measures are put in place to alleviate these where possible, for example there is currently an increase to the core domiciliary care hours in place. We also use demand projections to inform discussions regarding future capacity, particularly in relation to homecare and beds.

We use a range of tools to support this, including:

- **Affinity Landscape tool** – demand model and predictive tool used for the last 4 years to automatically generate intelligence showing trends and future predictions of all services, e.g. number of people accessing residential care, domiciliary care etc.
- **Capacity Tracker** – national on-line system that gives local intelligence on care providers in Darlington, including capacity and vacancy details by each provider, care home etc.
- **Activity reports** – existing range of reports that provide detailed information to managers – most of these are being transferred to the new Power BI tool on priority basis, e.g. ISPA report completed first, Team Activity report etc.
- **Liaison with independent providers** – regular weekly contact with all providers, regular provider forums allow detailed, consistent and comprehensive exchange of information and intelligence on both current issues and future developments.
- **Surge management** – 'Tees Valley Incident Command and Coordination Centre' call occurs on a daily basis, including Heads of Service for early intervention service along with health colleagues.
- **Weekly Darlington Systems Pressures group** – regular weekly meeting with Trust, ICB and Local Authorities to identify current issues and trends and related problem resolution and options planning.

This combination of meetings, tools and information sharing monitors performance and expenditure and identifies gaps and pressures to respond to any demand and capacity issues. These tools and information sharing mechanisms produce our statutory returns and enable us to have a better understanding prior to making any operational and strategic decisions. They have also informed us that in comparison to 2021-22, 2022-23 saw an increase in the numbers of referrals coming into the Health and Social Care system, but also allowed us to break this down by area, pathway, function etc. However, both the current and previous BCF Capacity and Demand data collections show a one-dimensional view of capacity and demand, and do not consider any waiting lists or trends in waiting lists, and activity projections do not show whether patients have been discharged on the most appropriate pathways. This is hidden demand that we are not currently capturing. It was difficult to use this data alone to accurately identify any shortage in capacity or unmet demand. We did however use the data alongside the local intelligence detailed above to inform further discussion/understanding and action including:

- It appeared that there were far more people being discharged on pathway 3 than we would expect, and the Discharge to Assess Model (Professor John Bolton) suggests should be the case, although this model is based on aged 65+ and we tend to report on all ages. Further discussion identified that this was due to the way discharges are coded to each pathway, for example someone returning to a Care Home is currently coded as Pathway 3. The figures for the other pathways had similar anomalies, which are currently being investigated further.
- Services are not commissioned in such a way that it is straight forward to measure the capacity for a certain element of them. For example, the staff members who deliver rehabilitation services also deliver other services, and the services they provide are flexed depending on the demand. This may mean that it appears we have sufficient enough capacity to meet the demand, but that is because of this flexibility and overall there may not be enough capacity in the system.
- Within Darlington the actual activity for Community Beds in at certain times in 2022/23 exceeded the predicted numbers. Work is ongoing to try to identify why, although we think there may be several reasons:
    - Increased activity in the hospital (both Elective and Non-Elective), including a surge in demand over the winter months.
    - Limited capacity in the domiciliary care market and increased pressure on discharge teams.
    - Workforce issues (sickness, recruitment etc) and restricted admissions due to outbreaks in Rydal resulted in more spot purchases
    - There has potentially been an increase in step-up placements.

- There may be instances where it appears there is sufficient capacity within the system, but this may not be the case:
    - There may be packages of care available, but not at the most popular times of the day (i.e. 9am calls)
    - Dom Care providers cover different geographical locations within the town, if one provider has no capacity the other may not be able to cover this area
    - Rydal Care Home can accept a maximum of 3 admissions per day, therefore if this limit has been reached there may be capacity in the home which cannot be used.
    - Care Homes have a limit of how many residents with 2-1 care needs they can admit due to staffing limitations.

This information has enabled us to negotiate and agree priorities to respond to the pressures identified – this could include discussing and agreeing alternative arrangements where demand cannot be met by the originally intended service.

These processes and tools allow us to keep a dynamic and up to date check on the capacity available, as well as the demand variation and the response to deal with this variation on a weekly basis, within the framework of the BCF and wider funding options.

2023/24 Approach to Capacity and Demand

As with last year, we have taken a joint approach to completing the Capacity and Demand information. This is necessary to ensure all Capacity and Demand is considered across the locality, however it also provides challenges, as to do this we require data from different information systems. This introduces the risk of missing some patients, double counting others and the systems are used to record information in very different ways. For this reason, we have made a number of assumptions when collecting the data, all of which have been documented in the assumptions section on the planning template.

Much of the low-level social support, including VCS, is provided by charity organisations and volunteers who support people on an ad-hoc basis. This includes helping with shopping, sorting bills and paperwork, cleaning and liaising with other services. There is no set time a person will receive this support and the commissioning of the services vary. Due to the nature of the of these services, most have no formal mechanisms in place to report how many people have been supported or for how long. Similarly, as many of these services use volunteers, the capacity can fluctuate quite significantly. We are not able to accurately report the demand for these services nor the capacity available to meet this demand.

When calculating the capacity of Care Home beds for reablement/rehabilitation we had to consider other factors as well as the actual number of available beds, including the workforce available to support people in the beds, and financial constraints. Because of this, the reported capacity does not include all available Care Home beds in Darlington.

This Capacity and Demand data collection does not include Mental Health data, as we do not currently collect this. We have initiated discussions to set up collection for this, however the data is not available for this planning submission. We do, however, have Mental Health representation in the weekly system pressures discussions and are aware of the pressures faced.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- Emergency hospital admissions following a fall for people over the age of 65
- The number of people aged 65 and over whose long term support needs were met by admission to residential and nursing care homes per 100,000 population

Falls response services are required in all systems for people who have fallen at home including care homes. We are therefore incorporating and building on the work in EHICH and UCR in order that we can provide a preventative and reactive comprehensive and coordinated community-based falls response for the Tees Valley.

This is to ensure people receive the right care in the right place at the right time, proving appropriate care to people in their own home. The proposal is to initiate a project to engage and consult with stakeholders to undertake a 3-stage process which will include scoping, mapping and reviewing what community falls services are currently available to support people who have fallen and those at risk of falling.

Following the phase one scoping stage, which will include a review of available digital data and discussions with stakeholders to identify relevant pathways and resources, phase 2 will be a mapping stage, plotting identified providers and pathways into services in order to understand the community falls offer across Tees and associated funding streams, review relevant data to develop a local picture of demand and responses from each locality and identify potential gaps and make recommendations for consideration.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge including:

- Ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow

Provide the right care in the right place at the right time

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 Tees Valley.

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 Tees Velley 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

Locally a group involving all partners led on the delivery of the discharge pathways. Operational leads contributed to the development of the Trusted Assessment tool, the system worked together to map out the pathways, the trust provided training to therapists to become trusted assessors, RIACT social care provided oversight of all discharges with the exception of the ICB commissioned beds, which were managed via RIACT health for a therapy or nursing handover to be completed as part of the process.

The ICB beds are commissioned to provide both rehab and nursing care in a facility with the equipment needed to promote faster recovery from illness or injury, i.e. a gym for rehabilitation. The beds can be accessed as both a step-up and step-down provision. Management of these beds were recently reviewed to provide RIACT Health and RIACT Social the opportunity to work together in managing the beds effectively. This has resulted in improved working relationships between partners including Discharge Teams, RIACT and Care Homes. Bed usage and outcomes are regularly monitored to ensure the best use of the beds.

The "Making Space" Rapid Response service (scheme 42 in the planning return) in Darlington provides an 8a.m. to 8 p.m.- 7 days per week domiciliary care service and supports the effective discharge flow from the RIACT team into community provision. The Rapid Response service is an essential element in the D2A- default discharge to a person's own home and provides an emergency response/ crisis intervention and aims to move on clients within 48- hours of discharge. The service is aligned with the ethos of the urgent community response initiative by promoting faster recovery from illness or injury and the facilitation of safe and timely discharge from hospital. It also prevents unnecessary admissions into Hospital.

Home from Hospital (scheme 34 within the planning return) is a scheme, working in partnership with the Local Authorities Care Connect Service, to ensure patients are transferred from hospital to home in a safe and timely manner.

In addition to the above we have completed a self-assessment against the High Impact Change Model and more recently against the new 100-day challenge initiatives on a trust wide footprint.

In the coming months we aim to:

- Continue to progress the Amber areas identified in the 100-day challenge self-assessment
- Assess if there are any gaps in the pathway 0 services supporting patients with low level needs to return home from hospital
- Review pathway 1 services, including the Rapid Response service and community reablement, to develop an integrated discharge pathway
- Continue to map the current core intermediate care bed base capacity, operational models, workforce, contract and funding arrangements to ensure we are meeting national guidance and achieving best outcomes to inform commissioning intentions and the future bed-based model
- Agree discharge to assess pathways and financial model from April 2023 onwards

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- Learning from 2022-23 such as
  - Where number of referrals did and did not meet expectations
  - Unmet demand, ie where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - Patterns of referrals and impact of work to reduce demand on bedded services – eg improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services

- Approach to estimating demand, assumptions made and gaps in provision identified
- Planned changes to your BCF as a result of this work

  - o Where if anywhere have you estimated there will be gaps between the capacity and the expected demand?
  - o How have estimates of capacity and demand including gaps in capacity been taken on board and reflected in the wider BCF plans

The 2022/23 ASCDF enabled investment into the following schemes:

- The incentive payment scheme was paid to 3 prime homecare providers to support recruitment and retention in the homecare market.
- increased the hours of the Rapid Response Service up to 250 hours per week, to provide reablement at home and to support discharge flow.
- Regarding home care pick-up rates, this investment has enabled a significant jump in package allocation when compared to January 23.
- We increased our intermediate short break stay (SBS) bed availability, for up to 6 weeks, to facilitate discharge until the end of March.
- Payment of advanced mileage to support packages of care in surrounding rural areas, has supported local retention and allocation of packages in areas which are difficult to accommodate due to their rurality.
- We also implemented time-bandings flexibility to enable providers to pick up the initial care package calls within a timeslot and then to subsequently rota calls into care agency regular runs. This supported pick-up rates.

Current Home Care Pick-up Rates:

- Prime Provider 1:- 75% (May 23) an increase from 58% in January 23.
- Prime Provider 2:- 92% (May 23) an increase from 52% in January 23.

Rapid Response Capacity:

- Increase from 150hrs per week to 250hrs. Total = 1589hrs between the 1st April – 21st May 23.

Short Break Stay Bed Capacity

- We increased intermediate short break stay (SBS) bed availability, for up to 6 weeks, to facilitate discharge. A circa 75 SBS beds was purchased by the fund. With the utilisation of the £200m fund we continued to fund 2 weeks (if needed) through the original ASCDF.

Residential Capacity:

- Total number of registered beds in in Darlington 1023. In the month of June 23 there is 81% capacity.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metric

- Discharge to usual place of residence

<u>Adult Social Care Discharge Fund</u>

To support local authorities to build additional adult social care and community-based reablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals.

Adult Social Care - Additional hours within key SW teams (5hrs per week per person involved)

Brokerage Strengthen current brokerage arrangements and build additional capacity to support discharge flow from acute settings
Extension of 1WTE Agency Worker

Care Market Schemes to facilitate discharge:

- Domiciliary Care: Extension of Time Bandings- extension of initiative for the commissioning of domiciliary care to improve “pick up” rates of providers
- Domiciliary Care: Mileage payments for Home Care - payment of enhanced mileage to encourage recruitment and retention of care workers
- Domiciliary Care: Rapid Response Service- increase capacity to enable timely hospital discharge and prevent avoidable hospital admissions

- Residential & Nursing Care-Additional intermediate /short stay bed capacity in residential and nursing care homes.

Market Sustainability & Improvement Fund

- **Maintain fee uplifts originally made as part of 2022/2023 Fair Cost of Care Grant for Domiciliary care & Residential care in 2023/24**

- **Homecare –** Additional payment for travel time which can be built into new contract formula

- **WAA Residential Care** – paying differential between 3% budgeted uplift and regional average agreed rate of 7.75%

- **Additional Commissioning and Contracts staff –** Agency staff member costs to support Market Sustainability work with providers

- **Additional ASC staff:**
    - WTE additional Senior Co-ordinator
    - 2.0 WTE Reablement Workers
    - reviewing officers or social workers assistants/OTA to enable capacity for more experienced workers to undertake the referrals on waiting lists (reviews and assessments)

- **Brokerage** Strengthen current brokerage arrangements and build additional capacity to support discharge flow from acute settings
    - 1 WTE additional Agency Worker
    - Digital platform to support brokerage of care packages

- **Finance** 1.0 WTE Financial Assessment Officer

- **Reablement** - Cost of ongoing budget commitment currently funded via iBCF

Streamline Assessment Grant

This Grant will support the reduction of waiting times for people who may have care and support needs. The use of this funding will be reviewed as part of the digital transformation workstream to ensure greatest impact.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

We continue to implement the High Impact Change Model for managing transfers of care and many examples of this are outlined in other sections of this template. In summary:

1. **Early discharge planning –** the transfer of care hub, daily system calls and on-going internal work with Trust colleagues
2. **Monitoring and responding to system demand and capacity –** the reporting mechanisms and daily and weekly multi-agency meetings
3. **Multi-disciplinary working -** examples include our ISPA and Integrated Coordination Centre
4. **Home first –** our system aim wherever possible and established D2A processes
5. **Flexible working patterns –** increased weekend working by social care
6. **Trusted assessment –** in place to support and expedite discharges
7. **Engagement and choice –** examples include our carers in hospital support and staff engagement with patients and families to seek the best outcomes but manage expectations
8. **Improved discharge to care homes –** well established EHICH processes and Trusted Assessors
9. **Housing and related services –** services in place to support with needs patients may have on discharge

National Condition 3 (cont)

Please describe how you have used BCF funding, including the IBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

All the schemes have been created to support the following to:

- build additional adult social care and community-based reablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals.
- increasing fee rates paid to adult social care providers in local areas
- increasing adult social care workforce capacity and retention
- reducing adult social care waiting times
- streamlining assessments to support the reduction of waiting times for people who may have care and support needs.

All schemes mentioned meet and deliver against our Care Act duties as listed below:

- Promoting individual wellbeing
- Preventing needs for care and support
- Promoting integration of care and support with health services
- Providing information and advice
- Promoting diversity and quality in provision of services
- Co-operating - to promote integration, cooperation and partnership with the NHS and other key partners to enable a care and support system which is person-centred.
- Safeguarding adults at risk of abuse or neglect.

Supporting unpaid carers.

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers

We will maintain and develop support for Carers to sustain resilience.

Funded through the BCF programme Darlington Carers Support and Humankind Young Carers Service to provide information, advice and guidance so that carers know what support is available and who to contact, 1:1 support tailored to individual needs, group activities and peer support and individual carer breaks. These are referenced in the planning return template, tab 5a, schemes 31 and 32.

Carer breaks are also funded through a number of additional providers to enable a broad range of carers to access breaks and support is provided to the carers of people with dementia via the Dementia Advisor and Dementia Friendly Communities contracts.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support including DFG funding that supports independence at home?

Across Adult Social Care and Housing there was a review of future housing needs in 2019. This had the overall aim of ensuring a strategic link between both areas and in ensuring residents could remain at home. This resulted in a new joint integration forum to ensure the

strategy was delivered as well as ensuring, operationally all future housing requirements/needs were delivered in a consistent way.

In addition to the new joint ASC and housing forum, the lifeline services continue to be provided by housing, and form part of the Adult Social Care reablement service and commissioned care packages. Lifeline services are also accessed by private funders. These services continue to provide people with the support they need to live in their own homes.

The Disabled Facilities Grant (DFG) is a key element in the maintenance of independence for older and disabled people in their own homes. People (and associated family carers) who have appropriate adaptations are less likely to be admitted into hospitals following an injurious incident. In addition, following discharge from hospital DFGs are applied to maximise independence and in turn reduce the risk of readmission.

The LA DFG lead is a key member of both the Darlington BCF Delivery Group and Pooled Budget Partnership Board . This ensures key involvement in planning and agreeing priorities during both the planning and review stages of the programme.

DBC updated its Disabled Facilities Grant and Regulatory Reform Order Policy in 2023, which further broadened the scope of how DFGs are used, including:

- Removal of the means test for: stairlifts (straight and curved); ramps (semi-permanent); level access showers; through floor lifts; wash dry toilets (and any combination of these)
- Retaining the means test for ground floor extensions and garage conversions but increasing the land charge recovery threshold from £5,000 to £10,000.
- Adding new schemes for:
    - provision of additional support such as safe spaces for children and adults with autism/behaviours that challenge
    - dementia grants to fund small modifications that would allow someone with a diagnosis of dementia to remain living safely in their home for longer.
    - smart home kits such as a smart thermostat to control heating and hot water
    - home accident prevention/health and safety such as minor adaptations and repairs, security checks, deep clean and de-cluttering of premises

The recharge of the cost for the Occupational Therapy Services (OT) for the time spent on completing Disabled Facilities Grant has also been increased in line with the increase in demand for DFGs, which enables more DFGs to be processed in a timely manner.

The increase in DFG funding in recent years has enabled DBC and its key partners the opportunity to review existing arrangements to ensure that adaptations continue to play a significant supporting role in enabling the Borough's residents to remain independent in their homes for as long as possible.

Usage of DFG has increased over the last 2 years for which information collated for the DELTA return is available.

This shows provision across housing tenure and age of applicants.

	2019-20	2020-21
Total number completed	96	112
Total number in excess of £30,000 (using RRO policy)	5	7
Owner occupiers	65	77
Housing Association tenants	21	16
Private renters	9	14
Aged 17 or under	11	17
18-65	30	35
66+	54	56

Information collected from the annual LAHS (Local Authority Housing Statistics) returns shows a small decrease in the total number of DFGs completed in 2021-22, but with a further significant increase in 2022-23. (DELTA returns are completed in November each year, so the DELTA return information for 2021-22 and 2022-23 is not yet available).

	2021-2022	2022-2023
Total number completed	98	147
Owner occupiers	78	135
Housing Association tenants	20	12

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services?   Yes / No

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking into account of people with protected characteristics? This should include:

- *Changes from previous BCF plan*
- *How equality impacts of the local BCF plan have been considered*
- *How these inequalities are being addressed through the BCF plan and BCF funded services*
- *Changes to local priorities related to health inequality and equality and how activities in the document will address these*
- *Any actions moving forward that can contribute to reducing these differences in outcomes*
- *How priorities and Operational Guidelines regarding health inequalities as well as local authorities' priorities under the Equality Act and NHS actions are in line with Core20PLUS5*

The local authority and ICB 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.

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.

In terms of BCF the prevention schemes support the most vulnerable, often those with long term conditions.

The four goals for the North East and North Cumbria Health and Care Partnership strategy are:

- Longer and Healthier Lives
- Fairer Outcomes for All
- Better Health and Care Services
- Giving Children and Young People the Best Start in Life

The summary of our NENC Health and Care strategy on the link below outlines the local challenges, goals and approach to prevention, fairer outcomes, Core20Plus5 and improving services across health and care for all.

https://northeastnorthcumbria.nhs.uk/media/bhrbrkt2/icp-strategy-v14.pdf

We will ensure that our BCF schemes continue to complement the local plans outlined above.