Northumberland BCF narrative plan 22/23

Introduction

This plan covers the intention of Northumberland County which includes provision of health and care providers directly within and surrounding areas. The key stakeholders are directly involved in planning the health and social care for our Northumberland system through our System Transformation Board (STB). The STB includes partners from the social care, local acute trust, mental health care trust, ambulance services, Healthwatch (VCS) and primary care. STB was established in 2017 and meets monthly to discuss areas of transformation, performance, and resource allocation to ensure the system supports health and wellbeing of all Northumberland residents. It ensures there is a forum to address key areas including all of those covered by the BCF agenda to support integrated care. The STB reports to the Northumberland Health & Wellbeing Board.

This report is expected to be discussed at the Northumberland Health and Wellbeing Board on the DATE 2022.

Executive summary

The priorities for Better Care Fund have been to jointly agree a plan between local health and social care commissioners which ensures NHS contributions to adult social care is maintained in line with CCG allocations, continue the investment in NHS commissioned out of hospital services and continue to improve outcomes for those people being discharged from hospital.

In line with national guidance, our local focus now includes ensuring continued ring fenced investment in NHS commissioned out of hospital services. Northumberland continues to meet the requirement to invest over and above the required minimum contribution to support care in the community. This investment supports discharge pathways and admission avoidance through community facing assets.

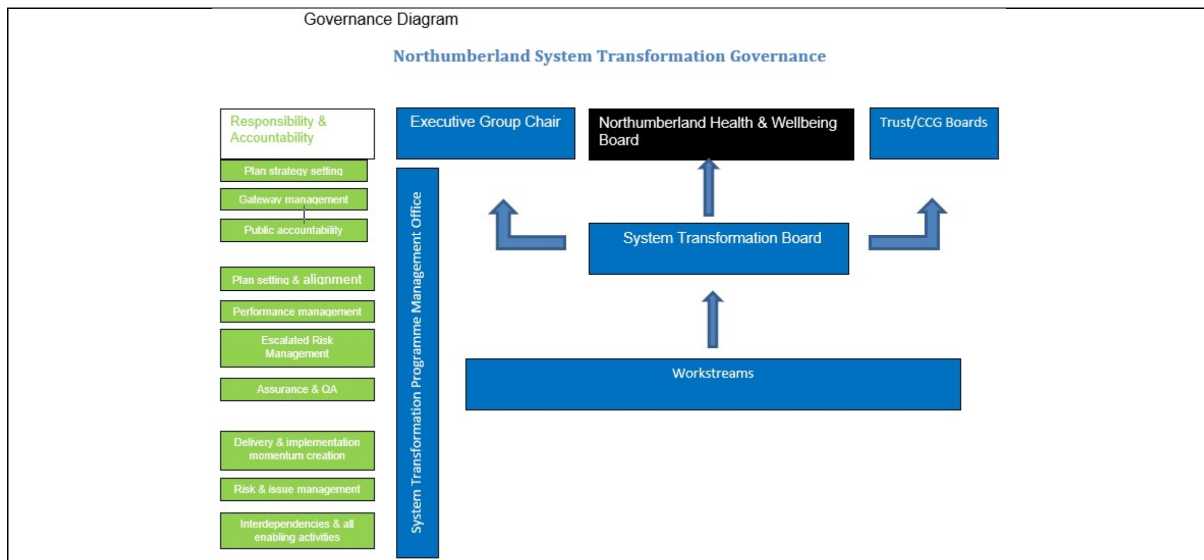
Locally, Northumberland is now looking forwards following a tough previous year dealing with pressures related to COVID. There is now a process to ensure all trust areas develop plans to meet backlogs created by the COVID related pressures. From the 1st of July, the Northumberland Clinical Commissioning Group because part of the Integrated Care Board for North East and North Cumbria. This now allows greater collaboration on a regional basis where this makes sense, whilst still focusing at place where there is expected to be continued drive towards integration with local partners. All local services continue to work closely together with available resource to deliver the best outcomes for our patients.

The Northumberland system is addressing inequalities through targeted work looking to address inequalities across the system. The work is looking to address both the underlying inequalities in the area which have been exacerbated by the COVID19 pandemic. This work is well underway and it has included holding a series of events across Northumberland with community leaders in each area. A comprehensive action plan has been developed which will work in conjunction with the BCF planning requirements.

Development of the plan has included the close working and involvement through priority setting work with local partners, including providers, VCS representatives, and locality authority leads (including house and DFG leads).

Governance

Our STB acts as the main vehicle to monitor the performance of key metrics including those set by the BCF and ensures delivery of the objectives. Through the close working relationships between health and care partners, our integration plans are put in place and delivered. To monitor newly identified metrics, agreement has been reached with system partners to meet on a quarterly basis to monitor and put in place corrective action where required. Ultimately the STB holds stakeholders to account for delivery and transformation. The integrated working relationships are key to ensuring successful delivery of our plans. The STB reports to the Northumberland Health & Wellbeing Board.



Overall BCF plan and approach to integration

The joint priorities for 22/23 are as follows:

- Ensure jointly agreed plans with a section 75 agreement to ensure elements of mandatory funding are used in accordance with BCF policy requirements. As part of the arrangement, ensure review of health inequalities and equality for people with protected characteristics to ensure plans comply the Equality Act 2020. As part of actions to address inequalities, each Primary Care Network (PCN) has selected a population health management project to address areas of inequality within their respective areas. Review of avoidance admission data and discharge data published via the BCF exchange to understand any performance issues at local level and agree plans to address issues including focus on objectives identified under Core20PLUS5.
- Ensuring that the CCG minimum contribution to the Better Care Fund is used to implement improvements in the area. This will include looking to continue to support carers' breaks and carer support, including support for carers of people in receipt of NHS continuing health care, which has been funded by the CCG, consider how reablement and rehabilitation resources support services to allow people to remain at home or return home following an inpatient episode. This will include the development of high level capacity and demand plans for intermediate care services covering both BCF and non BCF funded services.
- NHS contribution to adult social care will be maintained with the defined uplift to NHS minimum contribution which will ensure support from the NHS for social care services with a health benefit is maintained in line with growth in NHS minimum contribution to the BCF. This contribution will continue to support broadly the same areas as in previous years, but with a further strengthening of capacity in the HomeSafe service which supports discharge from hospital, which it is hoped will partially offset the impact of the ending of the nationally-funded Hospital Discharge Programme.
- Continue to ensure that funding is maintained for NHS commissioned out of hospital services. As in previous years, Northumberland has contributed more than the minimum spend required on out of hospital NHS commissioned services and this will be a continued priority as the area recognises the benefit to the system in supporting this area. Northumberland will continue to work with partners to ensure this area is developed and our residents receive the best possible out of hospital services which operate seamlessly across partner organisations. This will include the continued development of 2 hour urgent community response service which will support patients to remain independent at home, reducing avoidable admissions to hospital for ambulatory care sensitive conditions and in turn reduce inappropriate length of stay.
- Ensure the iBCF and DFG funding is spent in the most effective manner.
- Ensure that transfers of care are managed safely and effectively in our system including timely discharge of patient to right place with the right package of care using the home first approach.

The approach to our collaborative commissioning arrangements is to continue to use STB as the key board to discuss, agree and deliver transformation across our system. There are 5 flagship programmes which are driven by STB, which, although not directly related to BCF, ensuring integration of services across our system.

The approach taken to supporting people to remain independent at home, including strengths-based approaches and person-centred care includes:

- The Council introduced from 1 April 2022 changes to the way in which it organises its social work and care management services, designed to make them more person centred and more closely integrated with NHS community-based services. Community teams are now aligned either with primary care networks/clusters of GPs within primary care networks; or with specialist mental health, learning disability and other services provided by the CNTW mental health trust.
- Supporting the delivery of the Enhanced Health in Care Home Framework via the Primary Care Networks. This includes aligned support around our most vulnerable communities with regular check ins and link GP practice. Regular Integrated Care Home group which has stakeholders from across the system discuss commissioning arrangements, raise and resolve issues in a MDT way.
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- Use of Primary Care Commissioned Services to support primary care to take forwards workplans which look to focus on person centred care.
- Falls Forum which meets regularly to discuss and agree actions plans to improve management of falls and support education where required.
- The use of our Health Improvement Group which has stakeholders from across the system. This groups focus is to use the wealth of data we have across the system to address the inequalities and wider social determinates in our system. Each provider works individually and together to reduce inequalities in our system. This group includes strong links with the voluntary and community sector where there are significant amounts of work bringing our communities closer together with the recognition that true partnership working between the VCSE and health/care can bring about real change. Recent community events have look at collecting data to support the development of a plan to address inequalities, a draft of which is expected in the coming months.
- The care home, and frailty pharmacist service ensures that high risk patients at high risk of hospital received medication reviews to ensure medicines optimisation and evaluation has demonstrated that this supports admission avoidance.

The BCF funded services are an integral part to Northumberland's approach to integrated working which encourage providers to work closely together in best interest of our population. Although the former partnership between the Council and Northumbria Healthcare FT has now ended, relationships remain strong and the Council and the Trust intend to continue to work closely together in areas such as discharge planning, admission avoidance and reablement.

A separate section 75 partnership remains in place between the ICB and the Council, under which the council is responsible for commissioning on behalf of the ICB non-NHS care and support services for people eligible for NHS continuing healthcare (CHC), or for section 117 mental health after-care. The Council handles all associated administrative and financial arrangements on behalf of the ICB. This partnership also covers case management for care plans provided to meet continuing health care needs. Benefits of this partnership include

seamless transitions when people’s eligibility changes to a different funding source, and economies of scale in commissioning, financial processing and the arrangement and monitoring of personal health budgets and personal budgets for social care.

Implementing the BCF Policy Objectives (national condition four)

The strong integration between health and care within Northumberland enables the area to continue to support the important objective to enable people to stay well, safe and independent at home for longer and provide the right care in the right place at the right time.

The main mechanisms which support the successful implementation of this area are:

- A system transformation board which main focus is to ensure all services are joined up and wrap around the resident within Northumberland.
- Multidisciplinary team (MDT) CATCH working – this is an important area where primary and community teams are committed to working together in order to discuss the most in need patients, identify and introduce support. This is a proactive approach rather reactive model to 'catch' or avoid residents from unnecessarily being admitted to hospital. This is a challenging area given the wide geography in Northumberland and also issues with the care workforce, which have become more acute in the aftermath of the pandemic..
- The 2 hour urgent community response service which is a national requirement has built upon existing health and care services. A coordinator role is in place now which enables the identification of patients via referral who are not necessarily in need of 999/urgent intervention however would benefit from a more immediate response in order to avoid unnecessarily travel to hospital. This service further demonstrates the integrated approach Northumberland has taken, with health and care services meeting regularly to discuss how each service can work effectively together to meet the requirements of the national service and how this would best operated in the local area.
- The Discharge to Assess model is used by teams supporting the discharge from hospital process. As part of this process, resources are identified to ensure safe discharge and to allow time for recuperation, recovery, and ongoing rehabilitation or reablement in the most appropriate setting. This includes consideration of the essential criteria where supporting patients to go home is the default pathway however recognising that alternate pathways are sometimes needed. This includes use of a step-down facility to support the hospital discharge process, with care home accommodation supported by a team of therapists carrying out rehabilitation programmes. The focus is on person centred care with easy access to services and ensuring effective assessment is completed in a timely manor to ensure packages of support are in place.
- A short term support service managed by the Council provides reablement and therapy support which both reduces the risk of admission to hospital and supports people who may benefit during the weeks after a hospital discharge.
- Anticipatory Care – through the Primary Care Networks, there is a significant amount of work ongoing to support this agenda. This includes the delivery of the Enhanced Care in Care Homes framework which supports the proactive provision of care through aligned resources to care homes. All care homes within the area are fully aligned to a PCN who, working with health and care stakeholders, plan and deliver care. Also, all 7 of the PCNs have MDT processes in place which consider the needs of those residents who require further support in a community setting. The MDT approach has a core and wider team members involved in the planning of care provision, with information sharing and relationships between stakeholders key to the

success of proactive care. These MDT take the form of both virtual and face to face meetings.

The Personalised Care agenda continues to have significant focus across Northumberland, the key areas of development are:

- Social Prescribing – supporting the workforce across Northumberland including social prescribing link workers, health trainers and health coach workforce. There is a challenge in terms of the retention of staff and organisations from across the area are coming together to discuss how organisations can work together to support the roles. This includes consideration of supervision, mentoring, training, organisation culture, clarity of role and workload. The importance of social prescribing has long been recognised as it is clear we have many assets within our system and we need to work as a system to ensure we get best use of them.
- Support for the voluntary and community sector. The Council established in 2020, in part as a response to the pandemic, Northumberland Communities Together, a unit with a specific focus on building stronger partnerships between statutory and VCS bodies, bringing together and enhancing functions previously in separate parts of the Council. A new system has been set up to support capture of referral to VCSE partners as it was acknowledged that the system does not fully understand the significant amount of work progressed through the sector. The system allows further understand of activity and supports the highlight of areas and organisations where there are gaps and further support of our community based assets are required.
- A fund has been established within the local system which will offer funding bids to be received by voluntary and community sector to further support the sector which is vital need of protecting, complementing Council support for the sector.
- A Health Inequalities group has been established to support the system to take a Population Health Management approach to how it commissions services. This broadly takes the broad principles of:
    - Infrastructure – ensuring the correct individuals from across our Northumberland system are involved in the decision making process
    - Intelligence – ensuring we have not only the right data but the right individuals who are capable of interpreting or telling the story of what the data is telling us. This is essential due to the local nature of data which is capture due to the interpretations we have found in capturing data.
    - Interventions – developing evidence based interventions which are right for the residents within Northumberland as they have the correct individuals involved in the service developments and use the information collect. Research and Evaluation is a key part of this.

As part of meeting the condition, the area has completed a self assessment of the implementation of the High Impact Change model for managing transfers of care. As a result, a series of actions have been identified to support improvements in the areas where performance could be enhanced. Over the coming months, the actions will be completed.

We work in a collaborative way to commission discharge services across health and care. The collaboration arrangement including the discharge to assess model ensure there is support for safe, timely discharge which supports embedding of a home first approach and that residents are discharge to their usual place of residence where appropriate.

Supporting unpaid carers.

Within the partnership arrangement between the ICB (formerly the CCG) and the Council for NHS CHC, a consistent approach has been adopted to supporting carers, whichever funding stream is involved. Carers' needs are considered as an integral part of needs assessments and care and support planning, and whichever funding stream supports the person with care needs also covers support for the person's carer(s), with the principles in the Care Act being used as guidance when considering the needs of the carer(s) of people funded through CHC. The ICB's financial commitment to this is reflected in the BCF plan. This ensures that that the needs of the person and their carer(s) can be considered as a whole, recognising that in most cases the form of support that matters most to carers is a plan for the person they care for which takes full account of their own need to be able to balance caring with other aspects of their lives.

Through elements of the CHC system, which the Local Authority managers on behalf of health, there is significant support to carers. The BCF supports the commitment to providing support for carers eligible for CHC by providing them with breaks from caring. The Local Authority have a system called Swift, which is used to record whether an eligible person has a carer. As a system, we have reviewed how much of the day care which is being provided overall (including NHS related). This was mainly seen as support for carers of which we believe around half of financial support to day care is for that purpose. There are direct payments for short breaks which provides short term relief for carers.

The elements of the BCF expenditure which allow and support all carers, not just those who are directly supported by continuing care.

Disabled Facilities Grant (DFG) and wider services

The grant funding to support DFGs which is incorporated within the Better Care Fund will continue to be used primarily to meet the costs of the statutory DFG scheme, now augmented by a discretionary scheme introduced in December 2020, which focuses in particular on making funding equivalent to DFGs available to support a move to more suitable accommodation, where this is a better solution; meeting additional costs where necessary adaptations cost more than £30,000; and providing additional financial support in circumstances where the statutory means test produces unacceptable outcomes. Surplus grant funding not required for these purposes will continue to be used to support other capital expenditure on accommodation for disabled people.

The operation of DFGs and policy on use of the DFG grant element to support accessible accommodation outside the statutory scheme both sit within the adult social care directorate in Northumberland, which is a unitary authority. The Council's housing function has worked closely with adult social care and the CCG (now the ICB) to develop extra care and supported housing schemes.

There is an existing joint strategy for extra care housing and supported accommodation, which we plan to refresh during the remainder of 2022/3, and the development of schemes within the strategy is jointly supported by housing, social care and health. The Council's "Market Position Statement", a revised version of which is in its final stages of development, covers housing and supported accommodation schemes funded both through social are and NHS funding streams, and has been developed in consultation with the Council's housing service. The Council provides an in-house telecare service.

Equality and health inequalities

Northumberland has developed several important areas since the last iteration of the BCF plan. A Health Improvement Group has been formed which has stakeholders from across the Northumberland Health and Care system to identify inequalities and develop plans to reduce those identified.

The HIG was established just before COVID pandemic in 2020 and has formed successful partnerships across the system. Colleagues from public health are involved in the workings of this group and direction is set from the Joint Strategic Needs Assessment documentation. As part of the work, the Northumberland system has 5 Flagship Programmes which looked to address action in 5 key priority areas. The 5 key areas are given below and a summary of the work with each:

- Our Children and Young People – focus includes ensuring the Best Start in Life for this age group by working with community groups. This has included a focus on understanding the self-harm agenda and looking at projects which can ensure our most in need communities are resourced with service they need.
- Our Workforce – the strategic planning of our workforce across all sectors. This includes ensuring that Primary Care Network additional roles are considered within the wider system and ensuring a joined-up approach is taken to recruitment and retention as to not destabilise the system. We have embraced the use of apprenticeships and career start schemes.
- Our Communities – working closely with our voluntary and community sector include work with the "Northumberland Communities Together". This has included greater inter-agency working with a support to care organisations. This has include additional support to VCSE and introduction of a system to monitor outcomes.
- Our Connectivity – we are supporting the development of building blocks for our Population Health Management across the pillars of Infrastructure, Intelligence and Intervention. We have a network of individuals who have a collective but distributed leadership in supporting the reduction of health inequalities. This was included a £1 million fund to take forwards PHM initiatives in our system
- Our Culture – we are nurturing a relationship of trust between our stakeholders and continue to build an environment which allows recognition of challenges and an honest discussion on how to resolve.

The identification of inequalities of outcomes related to the BCF national metrics is taken forwards via our STB and Health Improvement Groups. As services, providers and the system, the identification and reduction in inequalities is top of our collective agenda. The goal of improvement on each of the BCF national metrics is seen hand in hand with this drive to reduce inequalities.