BCF narrative plan – Northumberland

Cover

Health and Wellbeing Board(s).

Northumberland.

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

Via our System Transformation Board, partners from the social care, local acute trust, mental health care trust, ambulance services, Healthwatch (VCS) and primary care.

How have you gone about involving these stakeholders?

The key stakeholders are directly involved in planning the health and social care for our Northumberland system through our System Transformation Board (STB).

Governance

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

Our System Transformation Board (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.

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 ICB 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.

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 and the ways in which those have been exacerbated by the COVID19 pandemic. A comprehensive action plan is in place and works 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).

This plan continues to build on the integration approach the Northumberland has followed with previous iterations of the BCF plan.

National Condition 1: Overall BCF plan and approach to integration

Northumberland has a long history of close integration between health and social care, though the organisational framework for this has changed a number of times over the past three decades in response to national reorganisations of the NHS, mergers of local NHS organisations, and changes in the preferred models for joint working adopted by NHS organisations. Currently, in addition to the mandated BCF partnership arrangement between the council and the ICB there is a separate section 75 partnership between the Council and the ICB (originally entered into with Northumberland Clinical Commissioning Group) under which the Council has operational responsibility for commissioning of continuing healthcare (CHC) and mental health after-care services from independent sector providers, and for case management and financial processing for CHC. 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.

Since 2021, there have been no formal partnership agreements between the Council and NHS providers. But following the ending in October 2021 of the previous partnership between Council and Northumbria Healthcare NHS FT, under which most operational statutory adult social care functions of the Council were performed by staff employed by Northumbria, the Council has been focusing on developing closer joint working arrangements with GP practices and primary care networks, and with mental health services operated by the Cumbria, Northumberland Tyne and Wear (CNTW) NHS FT, as well as aiming to maintain joint arrangements with Northumbria Healthcare, particularly to support hospital discharge.

In line with this change of focus, the adult social care community teams responsible for assessment and care coordination were reorganised in April 2022 into "care and support" teams, which work with people whose main contact with NHS community services is likely to be with primary care and community nursing; and specialist teams, which work with people whose primary contact with NHS professionals is likely to be with CNTW specialist services, such as community mental health teams, learning disability services, or substance misuse services. The Council continues to operate a "HomeSafe" team based in Northumbria Healthcare's acute hospitals, whose primary function is to ensure that urgent arrangements are in place to enable people to leave hospital once they are medically fit.

These changes have been made working closely with the "Place" team for Northumberland in the ICB, to ensure that the commissioning of community NHS services supports the integration of operational activity.

Because of our broader joint relationship, we see the Better Care Fund as one element in the wider financial framework within which we operate, rather than as funding for a distinct

set of joint programme. Our shared priorities for our "Place" for 2023-25 therefore extend beyond the schemes specifically funded through the BCF. They are:

- To review the impact of the creation of "care and support" teams, and explore the potential for further steps towards closer integration between these teams and primary care
- To continue discussions between the Council, CNTW and the ICB about closer integration of community mental health and learning disability services, including improvements to after-care planning under section 117 of the Mental Health Act
- To address current workforce capacity issues in home care services as a result of which we are currently not always able to make timely arrangements to support people in their own homes
- To continue to work together to address issues for care homes with nursing arising from current capacity issues in the nursing workforce
- To improve the availability of care home accommodation which offers skilled and person-centred support for older people who, as a consequence of dementia, are behaving in ways which create potential risks to other residents and to care staff
- To work together to further develop models for urgent community response which will provide alternatives to hospital admission, aiming to achieve the national target of two-hour urgent response. Because of the geography of Northumberland, it is unlikely that the best solution will be to adopt a standard model across the County.
- To support the development of a range of attractive housing options for older people with potential care and support needs, designed and located with the aim of maximising their independence
- To continue to develop the network of public sector initiatives working to support the many local community and voluntary organisations which support the health and well-being of the county's residents, and to guide individuals towards local organisations that can help them
- To work together across all services and with as wide as possible a range of other partners to take forward the commitments set out in the Northumberland Inequalities Plan 2022-2032

With regard to funding elements to support the initiatives, investment is expected to support improvements within the identified metrics. The further detail includes:

- Spending on the 2 Hour Urgent Community Response - which will increase the resources available to the existing services. This will support the capacity in our system to avoid the unnecessary conveyance to hospital for a range of issues including falls. It is expected this will in part support improvement in the falls metric.
- A scheme set up to support the Voluntary and Care Sector – allowing organisations to submit bids for additional fund which support Population Health Management and address health inequality issues. This process is already underway and organisations across Northumberland have submitted a variety of bids which will look to positively support our communities.
- Support to Primary Care Population Health Management projects – support to allow projects which address locally identified population health management projects via our Primary Care Networks is in place. This is now in the second year of running with significant positive feedback received and a variety of projects which look to support the integration agenda.
- Support to the community nursing service – this scheme funds part of the nursing service which is an integral part in delivering both proactive and reactive care to support our residents to remain at home for longer.

- Pulmonary rehabilitation service support – this is a key part of focus to support our residents with respiratory issues. It delivers both virtual and face to face support programmes in a group setting. It continues to receive positive feedback from those who have accessed the service. This is an example of supporting the delivery of the Core20Plus5 agenda.
- Supporting Community Hospitals – our community hospitals which are located across Haltwhistle, Alnwick, Berwick and Blyth are seen as an essential part of supporting flow across our system. They support rehabilitation in community bed setting. The community hospitals support the discharge process. Due to the geographical nature of Northumberland, the community hospital sites are placed in areas which allow placement closer to patient homes and support timely discharge.

Most of the BCF funding available in 2023-2025 is already committed to maintaining the core social care and community health services which are the essential foundation on which all of these priorities depend. New developments will primarily be funded through the Discharge Support Fund, the Market Sustainability and Improvement Grant which the Council has been allocated by the Government and core NHS and local authority budgets. Volumes of activity funded from the main BCF programme will in general be lower in 2023/24 than in the previous year, because unit costs have risen by more than the 5.66% increase in BCF funding, as a result of increases to minimum wage levels and other cost inflation, and the maintenance of these core services will have to be further supported from other revenue.

National Condition 2: 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.

Our overall approach is described above. Our plans in relation to the specific issues about which the template asks for further information are as follows.

Personalised care and "asset based" approaches

Arrangements for personal health budgets and personal budgets for social care have been harmonised in Northumberland. A standard assessment format used across all funding streams (CHC, section 117 after-care, and social care) includes an indicative personal budget/personal health budget to give the person a starting point for considering whether they would prefer to make their own care and support arrangements independently (but can be adjusted by agreement if it becomes apparent that the actual costs of support are good reasons higher than the indicative budget).

A single direct payments support team based in the Council provides advice and practical assistance to people who choose to manage the money themselves through a direct payment, regardless of the funding stream. Clinical advice about proposed plans can be accessed through the ICB, which is also able under the partnership agreement between the ICB and the Council to audit the clinical appropriateness and value for money of all individual arrangements, including arrangements where the personal health budget is "notional" or is held by a third party. The Council's corporate improvement plans for this year include a review of direct payment arrangements, which will also involve the ICB.

The Council teams which coordinate care planning are expected always to start from the outcomes which the person wants to achieve in their daily life, and to consider how all of the resources available to them in their family and social networks and their local community could contribute to achieving those outcomes, rather than framing assessments as a

mechanism for assessing eligibility for a defined list of formal health and social care services. We are currently considering how to offer staff further support in developing the skills and confidence to work in this way routinely.

Population health management, and proactive care

The Northumberland system has a collaborative approach to ensuring proactive care is delivered to our residents using a Population Health Management (PHM) approach. Northumberland has developed the PHM approach using a three step process; developing the correct Infrastructure, ensuring the Intelligence is available to make informed decisions, and building evidence based Interventions which are locally tailored.

This approach has been adopted after several successful pilot projects including the development of a comprehensive update to the Northumberland Palliative and End of Life strategy. This demonstrated the value in ensuring stakeholders are involved at the beginning of pathway developments or changes, involvement of the analytical capacity, ensuring that all data is considered as part development including engagement with local populations by working with independent agencies such as Healthwatch, and reaching a consensus on appropriate evidence-based interventions.

Northumberland has now several subgroups of STB which use the PHM approach to ensuring proactive care is at the forefront of service development. This includes the Community Collaborative Group (CCG) which performs a vital role in discussing and progressing issues surrounding our community services across our Northumberland integrated Neighbourhoods. This includes development of vital services to prevent hospital admission and ensure care is proactively administered to residents. The CCG group includes a range of stakeholders from across the health and care system with appropriately level of decision making ability. To date they have supported development of the 2 hour urgent community response service, the virtual ward introduction and operation of community services.

The virtual ward programme is continuing to progress well with an expansion inline with the national requirements. A project management structure has been implemented with regular reporting to all stakeholders and has support implementation processes. This includes share learning with our regional partner organisations. The virtual ward programme covers several specialty areas including Respiratory, Frailty, Surgery, Cardiology and General Medicine. The learning from specialties further ahead with virtual ward implementation such as respiratory has been used to support colleagues all clinical areas. Further significant increases in capacity are planned for December 2023 which is expected to support patients to remain at home in the busy winter period.

Another good example of the proactive PHM approach Northumberland utilises is through the Care Home Collaborative. This group was initiated during COVID pandemic and now meets on a regular basis to discuss and proactively improve care provision for our most vulnerable groups in a care home setting. This group ensures that national policy is adhered to including the Enhanced Care in Care Home Framework which is a key component to ensuring high quality care. This is a multidisciplinary group who come together to share expertise and learn across our system. A recent example of a piece of work was the pilot of a falls check list to capture care home views by self-assessment and provide additional support for falls prevention where required.

Multidisciplinary teams at place or neighbourhood level

The Council's approach to aligning its frontline staff with primary health care teams and specialist community teams in areas such as mental health and learning disability is described above. The Council's expectation since this approach was adopted in 2019 has been that where opportunities are available these frontline teams will be co-located with the

health professionals who work with the same people, which might include placing social care staff in primary care premises or in office accommodation shared with CNTW. We intend to explore further during 2023 the extent to which changes in working practices stimulated or accelerated by the pandemic may affect either the benefits of co-location or the opportunities to achieve it.

PCNs in Northumberland have a more complex geography than originally envisaged, and the model for developing integrated working will incorporate some adjustments to the Fuller Stocktake model to take account of the fact that some PCNs do not cover a single geographical neighbourhood, and that the diverse geography of Northumberland requires differing arrangements in different parts of the county. Our aim is to align the Council's care and support teams as closely as possible with the patient lists of an identifiable group of GP practices, to maximise the opportunities to develop close relationships between professionals working to support the same people. For the same reasons, CNTW have not found it practicable to align all mental health services with PCNs, and the council is currently considering whether its community mental health teams should be aligned with the localities around which CNTW organises services. However the general principles of the Fuller recommendations will shape future arrangements.

Our approach to support for unpaid carers, and to housing adaptations, and other housing initiatives is explained elsewhere in this plan.

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

Estimates are based on recent experience. As with capacity to support discharge, the key current issue is workforce capacity in home care, which we hope will improve during the year as a result of initiatives described below.

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.**

Unplanned admissions for chronic ambulatory-care sensitive conditions

Northumberland continues to develop a state of the art response to emergency medicines using the Northumbria Specialist Emergency Care Hospital, Base Sites and Community hospitals to provide a consistent, robust approach to supporting chronic ambulatory care sensitive conditions. The use of integrated teams across the community and acute sector enables this approach to support patients in the most appropriate setting.

Admissions following a fall

Northumberland continues to focus on falls for those over the age of 65. This takes the form of reactive and proactive services to ensure residents are supported appropriately in relation to falls. A mapping exercise is currently underway to understand the way each supporting service approaches falls and to ensure consistency across services in response to a fall. This includes working with partner organisations who may come into contact with individuals at risk of falls to ensure appropriate measures are put in place to prevent falls. The 2 hour urgent community response service is seen as the centre piece to reactive model once a

falls has occurred. This service, where possible, will avoid residents unnecessarily being taken to hospital as a result of a fall and instead, being supported to remain in the community. Due to Northumberland's geography, response to falls is something which is challenging and the approach taken is to develop existing services rather than develop new services which may struggle to recruit due to the limited workforce available across the patch.

Long-term admissions of older people to care homes

It remains the Council's objective to explore alternatives to care home admission wherever those are reasonably available. In recent years patterns of admissions have been affected by Covid, and it is still not entirely clear whether that continues to affect the numbers. There is also some risk that current capacity issues in home care could lead to an increase in the number of older people who become permanent care home residents, and this is one reason for the Council's proposal to invest substantially in improved terms and conditions for home care workers from the Market Sustainability and Improvement Fund.

Given the reasons for uncertainty, the short-term target in the plan is based on maintaining the existing level of admissions to care homes, which would imply a modest reduction in the rate per head of population. However it remains our objective to further develop both community services and housing options which reduce the need for older people to move into a care home.

National Condition 3: 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

In Northumberland a substantial proportion of available BCF funding has always been allocated to maintaining the level of core community-based services, and this will continue. Under a partnership arrangement agreed with the former Clinical Commissioning Group in 2013, and now transferred to the ICB, all commissioning of independent sector care services to support people eligible for NHS continuing healthcare or for after-care under section 117 of the Mental Health Act has been delegated to the Council, simplifying relationships with providers and ensuring a consistent approach across the local system.

A significant current obstacle to providing the right care in the right place at the right time is that since summer 2021 there have consistently at any one time been around 200 people who have been assessed as needing care and support, with care in their own homes as the right way to provide that, but who are currently not receiving home care because there is insufficient capacity in homecare providers. Regrettably, in some cases, it has been necessary to arrange short-term care home placements until a home care service can be sourced. In some cases, this is also leading to delays in arranging discharge from hospital, though overall levels of discharge delay remain low by national standards.

The Council will be using separate grant funding to further increase the fees paid to home care providers, and improve the terms and conditions of home care workers, with the aim of addressing the recruitment and retention issues which are causing current capacity problems. Some care providers in Northumberland are also now making use of care staff recruited from overseas using the Government's visa scheme, and there are early signs that this is leading to some reduction in the number of care packages which cannot immediately be sourced.

Our plans for the use of discharge funding prioritise flexible responses to the obstacles which can stand in the way of patients leaving hospital to return home or to find care home accommodation which can meet their needs.

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

Estimates of demand are primarily based on experience over the past year. Currently the major capacity issue we are facing is in the home care workforce – since summer 2021 we have had an unprecedented number of people for whom we are unable immediately to arrange the home care which they have been assessed as needing – the figure has fluctuated but generally been of the order of 200 people, including patients in hospital. The Council is planning to invest substantially in home care during 2023/24 and 2024/25 from the Market Sustainability and Improvement Fund, with the aim of making employment in the sector more attractive, and the capacity projections incorporate an estimate of the impact that we hope this will have on discharge capacity by the winter months. While the Council's initiatives are being not being funded through the BCF, they form part of an integrated overall approach to addressing the key priorities for heath and social care. The main elements of the Council's plans for the home care workforce are:

- A scheme introduced from the beginning of winter 2023/24 offering additional funding to home care providers in return for a commitment to pay home care workers at least the maximum tax-free rate of mileage payments approved by HMRC of 45p per mile. This was developed in response to feedback from providers that, because of increases in fuel costs, home care workers who are required to drive to visit clients, particularly in rural areas, were finding that the increased costs of this were leaving them out of pocket
- A further scheme implemented from July 2023, offering homecare providers funding to pay home care workers a minimum rate of £12 per hour – 10% above the "Real Living Wage", and more than 20% above the mandatory National Living Wage
- Another initiative scheduled to be introduced from October 2023, which will extend additional financial support further, linked to commitments to address some of the other key concerns of home care workers, such as fluctuating income.

Capacity in bed-based intermediate care will also be increased with support from the ICB element of the Discharge Fund. Over the winter period, additional intermediate care beds will be opened to support the expected increase in demand over this more pressured time. This will complement the existing intermediate bed capacity already available in the system. It will support hospital discharge and wrap around support from community teams. The capacity and demand tab with in the planning template reflects this with increasing Pathway 2 Demand and associated capacity from December 2023 onwards.

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

The local authority element of the Discharge Fund will be used to support a range of schemes aimed at ensuring that people receive the right care in the right place at the right time.

The majority of the local authority element will be used to ensure that funding is available to support rapid discharge on each of the key discharge pathways. We have shown this in the expenditure plan as four separate schemes based on our current estimate of how the funding will be allocated between different forms of support, but these schemes will be managed together to ensure that the overall funding available is used in the most effective way to achieve the underlying objective.

Some of the funding will be used to meet the costs of individual care packages to support patients after discharge, and to continue innovative models for home care introduced during winter 2022/23 with funding from the Adult Social Care Discharge Fund (though we will review during the year how well those new models are working, and how they relate to the wider changes in our home care commissioning arrangements). We are also exploring with providers a number of further initiatives potentially funded from these budgets, which we would expect to introduce in advance of the period of maximum winter pressures, including:

- Further exploration of ways in which we can support care homes to adjust their staffing rapidly to enable them to accept at short notice a patient ready for discharge from hospital. A pilot scheme established using the winter 2022/23 Discharge Fund was less successful than we hoped; we are discussing with care home operators suggestions they have made about why this was and what might work better. One issue raised by care homes is the disruption and cost caused when they bring in extra staff at short notice to be able to accommodate a discharged patient but the discharge is then delayed because of issues arising in the hospital or patient transport issues. We are discussing with them whether there is a case for guaranteeing reimbursement of extra costs in that situation.
- Changes to an existing scheme under which premium fees are paid for care home residents whose dementia is resulting in behaviour which care homes find difficult to manage without some additional staffing.

Finding appropriate discharge arrangements is often particularly difficult for those patients whose dementia causes them to have episodes of extreme confusion or anxiety during which their behaviour becomes a risk to themselves, other patients, or staff. In addition to exploring changes to the scheme providing additional financial support to any care home accommodating residents in that category, an element of the Discharge Fund will be used to support a separate scheme based on a block booking of 12 beds in a care home with specific expertise in supporting older people in this category. The intention is that this care home will be able to accept patients at the point of discharge, working with them to reduce their anxiety and establish effective plans for managing their behaviour, with the expectation that they will then be able to move on to a care home closer to their family or local community.

More generally, we expect there to be some improvement in the discharge to usual place of residence metric over time as a consequence of the enhancements to the terms and conditions of home care workers which are being funded from the Market Sustainability and Improvement Fund. Because inflationary increases to the cost of care services are this year greater than the increase in the NHS minimum contribution to the local authority, we will not be able to fund increased activity from the BCF, except for activity supported through the Discharge Fund element.

As the BCF team in NHS England is aware, the metric in use is interpreted differently by different NHS trusts, because of ambiguities in the definition of what counts as a person's "usual place of residence". The interpretation of this metric by Northumbria healthcare, the main acute trust serving Northumberland, which appears to us to be a reasonable interpretation of the specification in the NHS data dictionary, *excludes* from this category discharges of a patient who was already a care home resident before admission and who returns to the same care home on discharge. Our understanding is that the majority of NHS trusts nationally code discharges of this kind as being to the person's usual place of residence. As a result Northumberland's measured performance on this indicator is expected to remain significantly below average unless national steps are taken to ensure more consistent interpretation of the definition, but we do not think that this reflects below average performance,

though for reasons explained above we are currently less able than we would wish to be to arrange homecare services as soon as a patient is medically ready to leave hospital.

Set out progress in COVID is showing that seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system. This is successful, however, only if it is applied to all services including clinical decision-making and practical support services, including innovative use of virtual delivery. **implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.**

Since the ICB inception, a state of the art model has been developed to ensure delivery of the High Impact Change Model is in place. This uses a whole system approach to ensure best practice is shared and we achieve a resilient system across the NENC region. The nine core elements of the model are what leads this model including early discharge planning, monitoring demand & capacity, MDT working, using a home first approach, trusted assessor model, engagement and choice, ensuring effective care home discharge.

A ICB Director for System Resilience is now in place who plays a coordination role across the NENC system. Alongside this, there is now a well established data hub which receives daily updates from all community and acute providers across NENC, and compiles this in central repository which can be viewed via an iPhone App. This gives an almost real time view of system activity and allows the Resilience leads alongside Place leads to consider how to support organisations across the system, for example by organising mutual aid or diverting activity where necessary.

During the extremely busy winter period 22/23, daily discharge meetings were stepped up with a lead from each Place area taking part. This allowed each Place to highlight the issues they were experiencing and quickly develop pragmatic system solutions. For Northumberland, this highlighted the strength we have in having individuals with shared health and care roles in being able to pin point data and quickly put in place local solutions developed by the operational leads on the ground. The operational leads who are committed to making our system work with health and care worker are what continues to make the Northumberland system successful. The discharge meetings continue to be held but on a less frequent basis, this gives the opportunity to touch base and ensures that pressures are swiftly known and able to be resolved.

A Discharge Summit event was held with all stakeholders from across the system invited. It gave an opportunity to learn from across the wider system with both national and international models explored. This event was well attended and allowed stakeholders to come together to reflect on the recent system pressures and develop new ways of working. Although the summit was virtual, Northumberland stakeholders all convened at a central Northumberland location and this gave an opportunity to further develop relationships at local level. This continued strive to work in partnership, regardless of organisational structure and boundaries, is something which Northumberland is significantly proud of.

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?

The minimum BCF transfer to the local authority from the ICB and the iBCF funding continue to be used primarily to support core social care services, which are required in order to meet the local authority's duties under the Care Act. Since the Care Act maintains the principles of the previous statutory framework, in which the primary statutory duty of the local authority is to meet individual needs on the basis of personalised assessments, BCF funding is used to ensure, so far as possible, that there continues to be adequate capacity in social care services to meet all the eligible assessed needs of both people with care and support needs and carers.

In 2023/24, the capacity and sustainability of services will also be supported by expenditure from the Market Sustainability and Improvement Fund, the largest part of which is being used in Northumberland to support a substantial increase in the rates paid to home care providers, linked to increased expectations about the rates of pay and other terms and conditions of home care workers, aiming to put an end to the situation which has existed since summer 2021 where at any one time there have been of the order of 200 people who have been assessed as having eligible needs which would best be met by arranging care in their own homes, but whose needs no available home care provider immediately has the capacity to be able to meet.

The Discharge Fund will also enable us to adopt flexible ways to meet the local authority's Care Act duties towards people leaving hospital.

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.

Within the partnership arrangements between the ICB (formerly the Clinical Commissioning Group) 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.

Services provided to the cared-for person which are particularly important for carers, whatever the funding stream, include

- short breaks, including traditional short stays in a care home and more flexible arrangements, often supported through direct payments
- day services and support to enable the person to engage in activities outside the home without their carer (we estimate that in about half of all cases the primary reason for these services is to provide relief for a carer)
- sitting services to ensure that the person is safe at home so that their carer can do other things

Disabled Facilities Grant (DFG) and wider services

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

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 mainly to support other capital expenditure on accommodation for disabled people, though by agreement with the Place Director for Northumberland in the ICB it may also be used for some other social care capital schemes.

In recent years, there has consistently been funding from the grant available to support schemes over and above meeting all mandatory DFG applications. Since we do not yet know how the additional DFG funding announced for 2023/24 and 2024/25 will be allocated, and inflation has increased construction and related costs, we cannot be certain what the position will be in those years, but our planning assumption is that we will continue to have some scope for investment in other schemes. There are no waits for DFGs related to funding availability, and we have no reason to think that DFGs are significantly under-publicised.

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, and the senior manager responsible for the operation of the DFG system is part of the adult social care senior management team which shapes the advice about strategic developments given to the Council. The Council's housing function has worked closely with adult social care and the ICB to develop extra care and supported housing schemes.

There is an existing joint strategy for extra care housing and supported accommodation, and the development of schemes within the strategy is jointly supported by housing, social care and health. Funding from the DFG grant not required to meet statutory DFG obligations and eligible needs and the local discretionary scheme has been used to create a fund which is available to provide support with the development of extra care and other accommodation based schemes. The Council's Market Position Statement covers housing and supported accommodation schemes funded both through social care and NHS funding streams, and has been developed in consultation with the Council's housing service. The Council provides an in-house telecare service.

Supporting the development of housing suitable for older people and others with disabling health conditions is a critical component in developing a community infrastructure which enables patients to return home from hospital safely and without delays.

<u>Additional information (not assured)</u>

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? (Y/N)

Yes

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

The discretionary policy is available if any of the situations described in the policy arises, funded from the same budget as mandatory DFGs; to date there has been no need to create a separate budget limit. The policy sets out three circumstances in which grants can be paid:

- to support someone to move to alternative more suitable housing, in cases where adapting the person's existing home would not be the best way to meet the person's needs, or would be impractical or unreasonably expensive

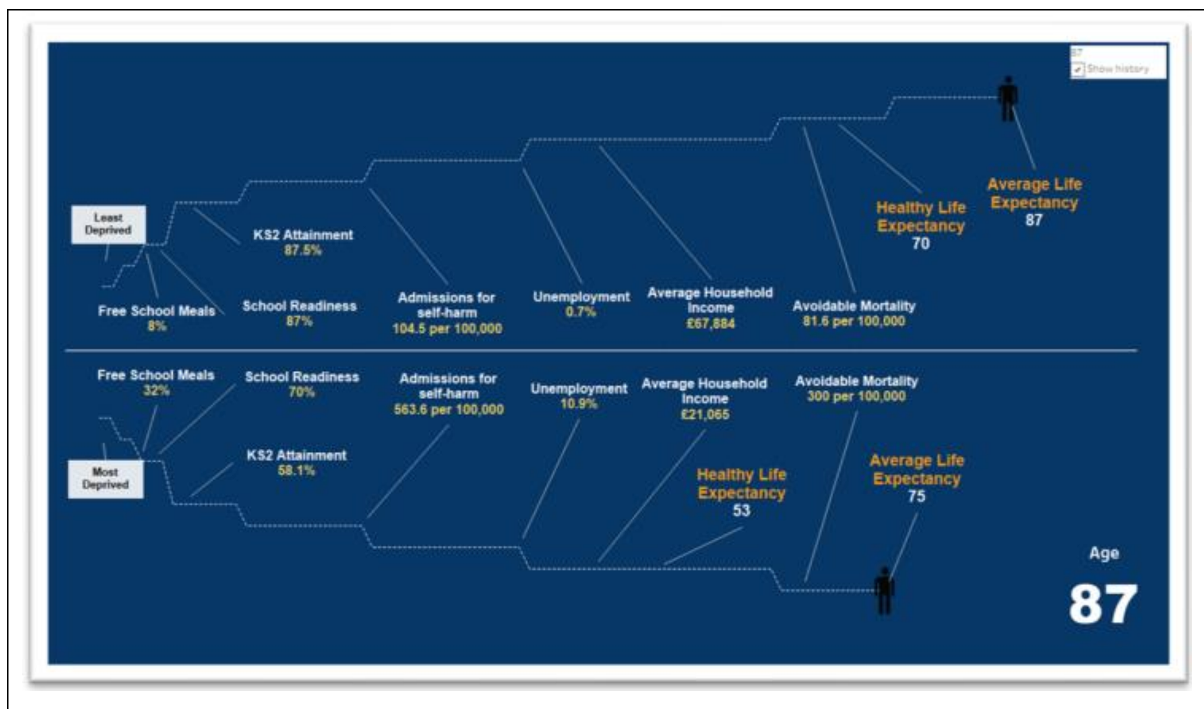
- to cover the extra cost of adaptations that a person needs which are more expensive than the nationally set limit on DFGs
- to provide additional support in special circumstances where the means test for a DFG would otherwise make it difficult or impossible for someone to afford adaptations which they need

Northumberland is a unitary local authority, so there is no district council structure in the area.

Equality and health inequalities

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

Residents in our most deprived communities have an average life expectancy of 75 years compared to 87 years in the least deprived; 12 years more of life if you have the benefits that come with the lowest levels of deprivation. There is a 17-year age gap in good health (healthy life expectancy) between those living in the least deprived areas and those living in the most deprived communities; 70 years of living in good health compared to 53 years. Figure below shows the level of inequalities which exist across the life course for a range of indicators across Northumberland communities.



The context for our BCF Plan is set by the Northumberland Inequalities Plan, endorsed by the Health and Wellbeing Board and adopted by the Council in September 2022, which is available at www.tinyurl.com/Inequalities22. The Plan sets out a common purpose and ambition to reduce health, social and economic inequalities in Northumberland, based on a system-wide commitment to focus on a few key enablers which will support an improvement in a focused collection of short, medium and longer-term indicators which will demonstrate that inequalities are narrowing and outcomes for our residents are improving.

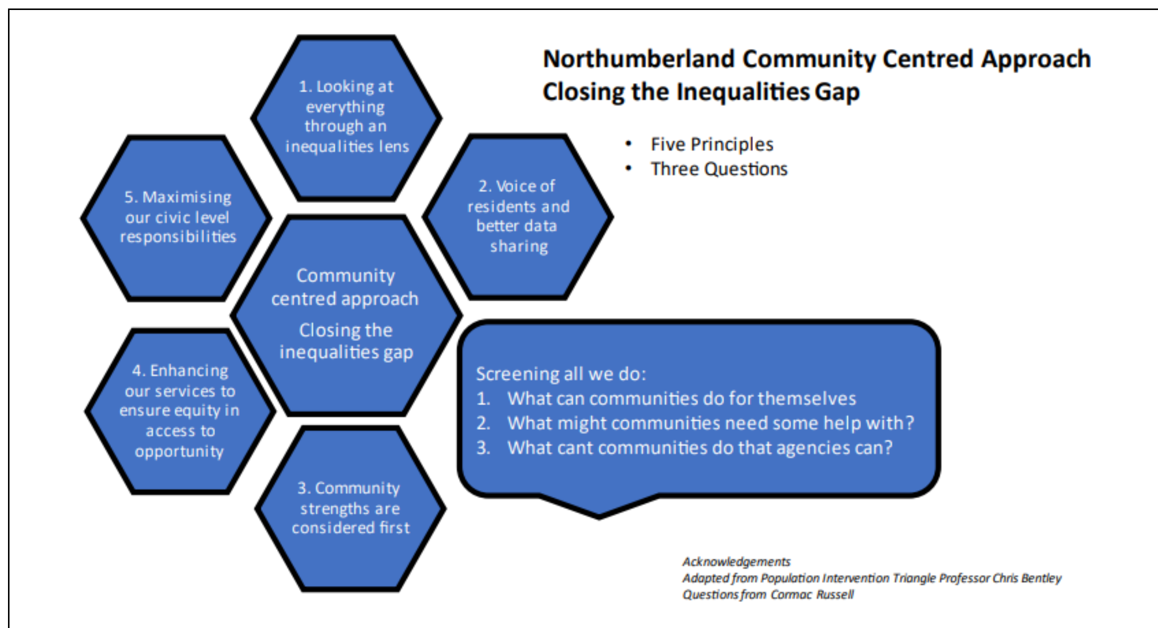
The plan drew on locality conversations in which almost 400 stakeholders such as VCSE, local staff from public sector, private sector (senior officers to front line) town and parish councils and, elected members participated.

The plan is based on five principles:

- Look at everything through an inequalities lens
- Voice of residents and better data sharing
- Community strengths are considered first
- Enhancing our services to ensure equity in access to opportunity
- Maximising our civic level responsibilities

All participating organisations have agreed to ask three screening questions in all we do:

- What can communities do for themselves?
- What do communities need some help with?
- What can't communities do (even with help from outside agencies) that agencies/institutions can do.



As the Northumberland Inequalities Plan was created from the ground up, it was not specifically developed using the NHS Core20Plus5 model however the general concept of focusing on the most deprived communities remains the same. The Northumberland Inequalities Plan is about reducing the inequalities for those who are at most need, namely the most deprived 20% of our communities. The bus journey map of life expectancy is reality check of the work we still have to do to address the inequalities work in the most deprived communities.

Equally, through the System Transformation Board, the 5 key clinical areas are something which the Board very much are the day to day focus in terms of addressing the inequalities. This includes comprehensive workplans for Maternity, Several Mental Illness, Respiratory Disease, Cancer Diagnosis and Hypertension Case Finding.

An example of some of the focused work includes:

- A Respiratory Collaborative group – this includes clinical colleagues, public health and commissioners who come together monthly to share national and local guidance, develop action plans and address the issues. This group has met for a number of years following development from the RightCare national focused group. The collaboration stretches across both Northumberland and North Tyneside areas which makes sense given sharing the same Acute trust. A recent example of working includes a specific communication developed by partners to support those patients at most risk of emergency admission during the winter period.
- Cancer Joint Working Group – system group has a comprehensive action plan and meets regular with a range of system partners including strong engagement with the voluntary and community sector partners.
- Smoking Cessation – working with regional colleagues, a comprehensive strategy is in place to support reduction in smoking cessation.
- Cardiology Collaborative – a group meets regularly with system partners including clinicians from primary and secondary care. This group includes focused working on projects to support lipid management.

Changes to the BCF plans have been screened for equality impacts. In most cases, funding will continue to be allocated to the same services as previously, and no new issues about differential impact based on protected characteristics are expected to arise. In general, almost all of the funding is expected to support disabled people.

Because most funding will be allocated to individuals based on individual assessments, it is expected that specific issues relating to protected characteristics will be taken into account during the assessments.