HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Tameside 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).

NHS trust service representatives
Social Care Provider representatives Including Director of Adult Social Care
Local Authority Commissioners
NHS GM ICB representatives

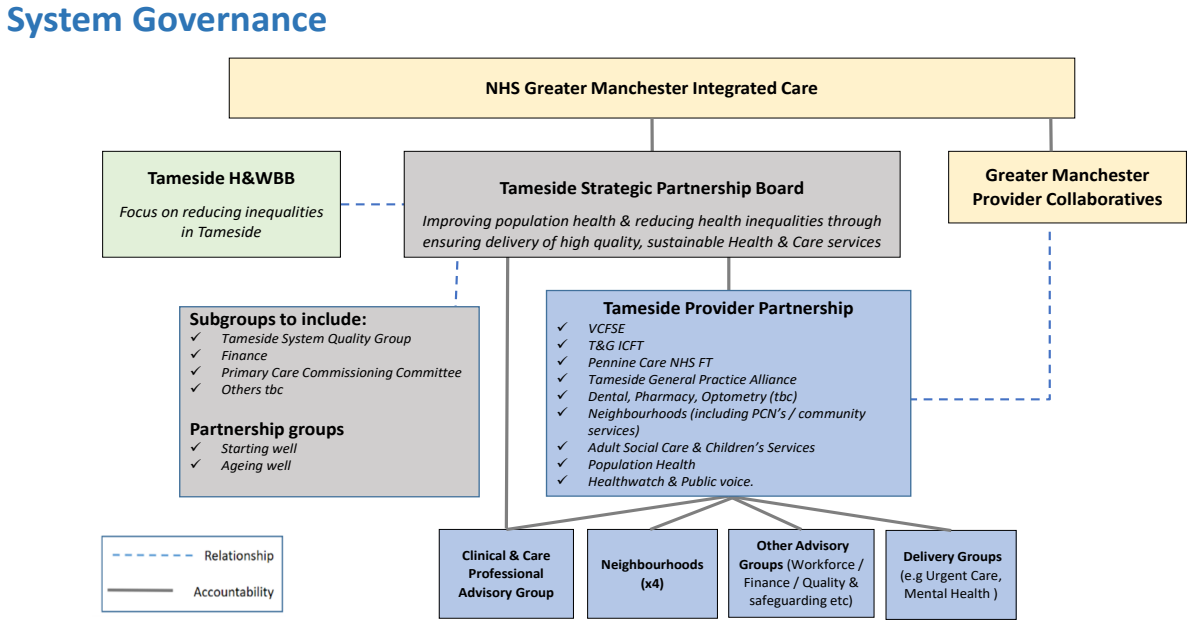
How have you gone about involving these stakeholders?

We have reviewed the impact of existing schemes against requirements, including the discharge funded elements from 2022/23 to determine where schemes should continue or be enhanced as having significant impact and/or if new schemes could/should be implemented.

This engagement has been undertaken via local authority colleagues engaging with NHS service leads, VCSE, Housing Authority, Social Care Providers and Private sector organisations through existing governance groups including contracting and operational delivery meetings. This work is also intrinsically linked to the development of Tameside Locality Plan.

Governance

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



Executive summary

This should include:

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

- Ensuring integrated working is maintained
- Supporting the care market to forward plan on the basis that funds are available to support pressures in the system and recruit accordingly
- Ensure that our Urgent Care Response Service has appropriately skilled care and support staff to aid management of patients within the service
- Admission Avoidance plan is enhanced and strengthen following the success of schemes developed with 2022/23 winter discharge funds
- Ensure that local services are aware of equipment and personalised care budgets to maintain patients their independence and live well at home for as long as possible

As Tameside services already work as an integrated system it is not envisaged that there will be significant change to ways of working to last year but rather sustain and improve.

Tameside's Locality Plan is currently being refreshed and due to be released in summer/autumn 2023 with a renewed focus on the vision that Tameside is a happy, healthy and ambitious place where people choose to live and work. We want to co-develop person-centred, resilient asset-rich communities that support residents to live great lives. Our principal objective is to integrate services around people and their needs. This will involve furthering the pioneering work undertaken in Tameside to integrate health and care services and creating a system of co-located professionals from all public services working together as one integrated public service across our locality and within our neighbourhoods. The integrated nature of work in Tameside to achieve this vision is reflected in the joint approach to the development and publication of the borough's Joint Health & Wellbeing Strategy alongside the refresh of the Locality Plan, both of which are being developed into one product to align our borough-wide, place-based priorities.

The priorities of the Joint Health & Wellbeing Strategy are around a golden thread of tackling the inequalities our communities face in all work and services across the system; alongside maintaining a focus on longer-term approaches to tackling and improving the wider determinants of health, putting the current priorities of the Health & Wellbeing Board at the centre of this: poverty; work & skills; and healthy places.

The Better Care fund is a key enabler to deliver integrated health and care services which are based on the high impact change model (HICM). The work is led collaboratively through ICB (Tameside), ASC and Health colleagues across the system to support the continued investment and delivery in existing schemes whilst continually exploring opportunities to enhance and refine arrangements to improve outcomes for individuals ensuring they receive the right care in the right place at the right time. Collaboration and development of these schemes is through the Provider Partnership Board with assurance to our Strategic Partnership Board and Health and Wellbeing Board.

Operational delivery is through smaller working groups working with partners via our leads in both health and ASC with operational oversight a key feature of our locality Urgent Care Board and weekly Executive LOS meeting that review system capacity and demand, patient flow, Delayed Transfers of Care. Key risk areas are reviewed regularly from an operational perspective at system level and actions agreed across agencies so there is system wide ownership reducing duplication.

Integrated working has been embedded for a number of years in Tameside's Integrated Urgent Care Team (IUCT) which ensure sufficient adults social care and community health service capacity to deliver the national discharge requirements based on local demand. The BCF also makes provision for a housing officer and trusted assessor roles as part of the discharge function ensuring clear pathways for those with housing support needs and discharge to our Support at Home services.

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.

The refreshed Locality Plan and Joint Health & Wellbeing Strategy for Tameside sets out ambitions to improve the longer-term determinants of health and wellbeing across the borough , which will remain the focus of Tameside's Health & Wellbeing Board. The Locality Plan proposes that this will be achieved by building back fairer, stronger, together across the lifecourse. This will involve a relentless focus on tackling inequalities via people and community powered health and wellbeing. Our approach will incorporate proactive, predictive and personalised prevention.

A new locality governance structure for integrated health and care is now in place which is overseen through the Tameside Strategic Partnership Board and aligns to the Tameside Health and Wellbeing Board and the Greater Manchester Integrated Care Board. This structure will ensure that the vision set by the Tameside Locality Plan and Joint Health & Wellbeing Strategy that Tameside is a happy, healthy and ambitious place where people choose to live and work is delivered. This structure creates an integrated care system at every level with revitalised strategic partnerships providing system design and assurance built around the Health & Wellbeing Board and Strategic Partnership Board. The Tameside Provider Partnership and Tameside GP Alliance seek to ensure the continued close working arrangements between Adult Social Care, Public Health and Health Care services and that 'we' work as 'one' system to invest the 'Tameside £' improving outcomes for individuals as efficiently as possible. This will be achieved through the special levels model of Strategic design (Strategic Partnership), design and delivery (Provider Partnership), and delivery (neighbourhood partnerships). In addition, there are a range of sub groups which ensure specific focus on key programmes of work such as Urgent Care delivery board. The governance and delivery of local schemes is multi agency and integrated.

Locally we have integrated plans in place for Urgent Care, LOS and discharge, out of hospital 2 hour urgent care response all of which are supported and embedded through BCF funding.

Our current priorities are:

- Increase the number of people helped to live at home
- Reduce hospital admissions due to falls
- Increase levels of self-care / social prescribing
- 'Good' and 'Outstanding' social care settings
- Prevention support outside the care system

Tameside have long-standing models of integrated Urgent Care teams which were established following the inception of the BCF and have gone on to be recognised as good practice both in GM and nationally. (National Cond. 2 for more information)

Another key principle which our integrated system will continue to work by is to be evidence informed.

The Tameside Joint Strategic Needs Assessment (JSNA) provides a suite of tools and documents that assess the health and wellbeing needs of the Tameside population. This is in place and is undergoing substantial work to develop more insight and recommendations to inform system wide decision making and resource allocation. This also builds in resident voice to ensure the intelligence is broad and not only based on data but also what it feels like to live in Tameside.

The Ageing Well JSNA has now been published and identifies that whilst Tamesides current 60+ population is smaller than the national average and statistical neighbours, we do have a larger 50-59 population suggesting a growing older population. We expect the many of our older groups in the population will increase in size over the next 20 years.

- Over 65s will increase by 20%
- Over 80s will increase by 69%
- Over 90s will increase by 92% (small numbers)
- More of this growth is expected to be among males with smaller growth in females
- In contrast to most age groups, under 50 seeing only single digit % increases

Given the ageing population, Tameside has recently published a comprehensive 5-year Housing Strategy 2021-2026 and these points, drawn from analysis that informed the strategy, highlight the particular need in relation to specialist and support housing. This will be further enhanced with a Care Market Position Statement and commissioning intentions to support market shaping activity in the locality during 2022/23. We will continue to be innovative in developing specialist accommodation support for people with specific needs such as using Disabled Facilities Grant (DFG) funding flexibly to better meet the needs of our residents.

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 deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned 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.

The systems we have in place, following several years of integrated working are strong and we are committed to retaining these where they continue to add value. We will continue to uphold the concept of primacy of place. We will work to the followed place-based principles to support integration and collaboration at all levels.

Principles	We will…
Partnership	✓ We will be accountable to the local population and to each other. ✓ We will co-design and co-produce services with residents and community partners.
Powered by people	✓ We will empower our population and support them to take responsibility for their own health and wellbeing. ✓ We will recognise and develop resident, voluntary, clinical, political and managerial leadership. ✓ We will empower our workforce to work in collaboration across organisational, professional and service boundaries.
Person-centred	✓ We will take a proactive and preventative approach, intervene early and respond to the person in the context of their community. ✓ We will develop place-based approaches to tackling the social determinants of health that build on the assets within our communities.
Productive	✓ We will implement ways of working that support collaboration not competition. ✓ We will work together to make best use of financial, workforce, estate and other resources. ✓ We will maximise social value and jointly manage the system budget sharing risks, deficits and surpluses.
Progressive	✓ We will create a 'can do' culture with a focus on innovation and continuous improvement. ✓ We will develop a strong learning culture where new ways of working are reviewed and evaluated.

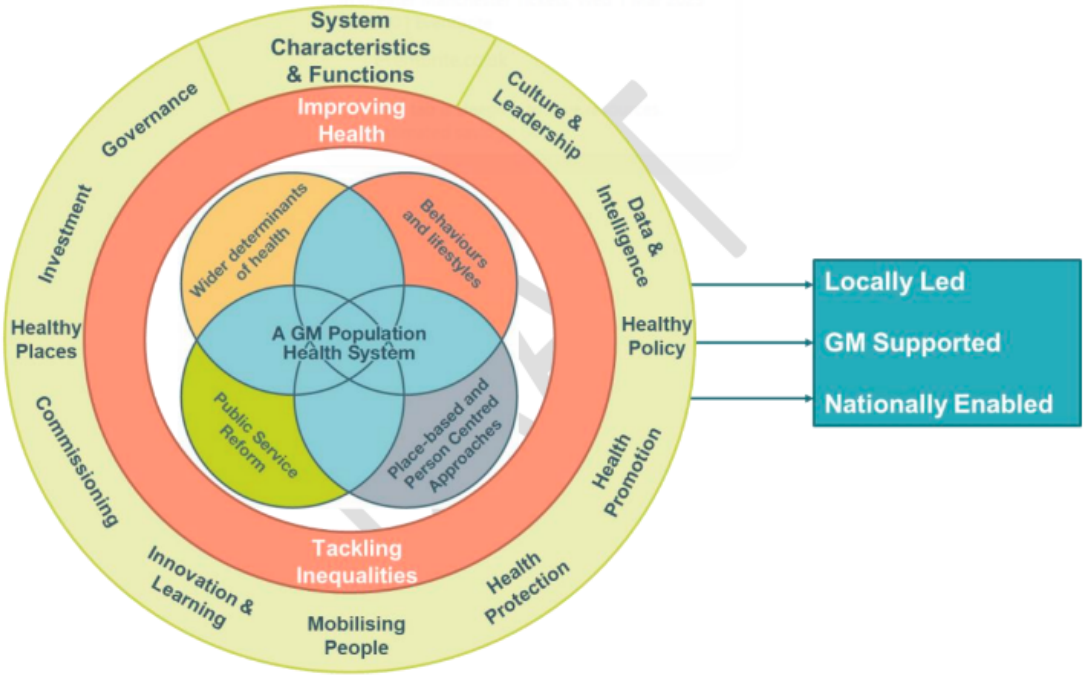
As part of the established governance structure (Tameside Strategic Partnership Board; Provider Partnership; Neighbourhood Transformation Group) there is ongoing work to ensure an evidence and data led approach to population health management. This includes direct support for primary care networks around predicted vs observed prevalence of key conditions and risk factors which drive some of the biggest outliers, inequalities and causes of morbidity and mortality in Tameside.

The GM Population Health Characteristics Framework sets out the conditions, characteristics and functions required at different spatial levels for a whole system approach to population health to be in place in Greater Manchester. It recognises the importance subsidiarity and of place in determining what is required at difference spatial levels in order to maximise impact.

We will capitalise on the opportunity to implement the GM Population Health Characteristics Framework to ensure a whole-system approach to population health. This recognises what we need to do together across Greater Manchester but also what needs to be in place and be done locally in Tameside to achieve the best outcomes for people in our borough.

Some of the key local functions required at a borough level to enable this population health framework approach include:

- Everyone recognising the importance of improving health and reducing inequalities
- Our local approaches should focus on learning and improvement
- There is effective partnership working between Greater Manchester organisations (e.g. the GM Integrated Care Board, and the Greater Manchester Combined Authority) and local Health and Wellbeing Boards and VCFSE sectors
- A range of person and community centred approaches are taken to involve people living in the area in our delivery and services
- There is a vibrant and sustainable VCFSE sector
- Priority is given to investment in improving health and reducing inequalities, including shifting the balance of spend towards prevention and early intervention.



National Condition 2 (cont)

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, i.e. 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 – e.g. 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.

The wider JSNA will continue to be developed and drive decision making around the key areas of insight and intelligence where this provides forecasts around predicted demand; key priority outcomes to drive improvement in Tameside; and where critical service gaps are highlighted. The JSNA steering group and Health & Wellbeing Board for Tameside will drive the findings of relevant individual pieces of work to inform system wide decision making.

The recently published Ageing Well Needs Assessment for Tameside highlighted that there are some cohorts of older people who experience multiple challenges and may require a greater range and level of support. Particular risks that many people face all of include living alone, being income deprived, living in fuel poverty. There are also some groups who face particular inequalities, particularly older women, people from ethnic minority communities, and people living with a disability. This work also highlighted some key areas which may present demands and require further work to tackle inequalities and enable support including digital literacy and inclusion; awareness of support available for carers, and supporting mental health and learning disabilities.

Approach to system performance management An integrated Business Intelligence function has been developed led by The Chief Data Officer. Currently this includes analysts from T&G ICFT & GMICB Tameside who work closely with colleagues in Tameside Council.

Performance oversight and scrutiny is provided via Locality Governance including the provider Partnership, Strategic Partnership Board and Health & Wellbeing Board. An outcomes framework is under development, which will provide measurable indicators at neighbourhood, Provider and system level.

The introduction of Client Level Data Set (CLDS) for Adult social care provides the opportunity to link with NHS data and records helping us to understand more about who accesses care, how and with what impact. This alongside GM Tableau is helping the locality to better understand the capacity and demand across the system and ensure that models of care and support are planned and delivered in an integrated way.

Year End Summary 22/23

During 22/23 the system applied a key focus on hospital avoidance for our frail eldery residents by implementing our Acute Frailty Service. This service provides early proactive identification and subsequent management of over 65's with acute frailty syndromes to avoid admission in the first place or early discharge where admission is required. This service will be continued during 23/24.

Robust executive oversight has seen the numbers of delayed discharges consistently reduce during 22/23 this achieved thorugh a system wide improvement programme (see National condition 3 for more information. However we have also continued to see some challenges in the numbers of people discharged to residential care and therefore a review of D2A pathways is a key priority for 23/24.

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.

Integrated Urgent Care Team

The Integrated Urgent Care Team (IUCT) is a multi disciplinary service, consisting of registrant nurses, social worker, physiotherapists, occupational therapists, technical instructors, and care support workers. The IUCT is an enabler for supporting people to remain well, safe and independent at home longer with two integrated models of care: two hour crisis response service and intermediate care. The two hour crisis response supports people who are acutely unwell that can be safely supported in their own home reducing the requirement to access urgent care services. The Intermediate Care provision in the persons own home is facilitated through multidisciplinary assessment and support package, where appropriate this can be accessed within 2 hours of referral as part of the Home First pathway or as a Crisis Response i.e. fall in the persons own home.

Expanding Intermediate Care in the persons own home will deliver better outcomes for people, evidence suggests 92% of people who access intermediate care have an improved dependency score and 72% do not move to a more dependent care setting (SCIE, 2017).

Learning from 2022/23 (Expanding intermediate Care bed provision), in many circumstances this support can be provided in the persons own home with adequate wrap around care. This reduces the requirement for increased intermediate care bed based provision but requires expansion of the multidisciplinary team within IUCT including Advanced Clinical Practitioners as demand increases so that this can be safely provided in the persons own home.

Digital Health and Community Response Service

Digital Health work in partnership with Tameside MBC and complement the Community Response Service (CRS) thus allowing and assisting with independent living in the service users own home with digital technologies to support. CRS wardens carry devices which allow the Digital Health Team to undertake timely assessments via video of patients into the hospital for a rapid and timely assessment of care and for the team to wrap care around the patient in their own homes, therefore ensuring that only those individuals who need to attend / transferred to the Emergency Department do so. As part of the Community Response Services' offer it supports those patients identified as having a high frailty indices within our local neighbourhoods, many of whom are currently unknown to service providers but are vulnerable and, with this intervention, could have hospital admissions avoided through pre-emptive intervention via the CRS team and NHS Digital Health Service.

Tameside Community Response Service is an emergency response telecare service for anyone over 18 years old, regardless of personal circumstances. We operate 24 hours a day, 365 days a year; we will respond whenever help is required. We provide a variety of different devices and sensors to suit the needs and health of the individual. Some devices are activated by the user; others are triggered automatically by sensors installed in your home.

Discharge Teams (IUCT)

Tameside's integrated discharge team (within IUCT) delivers the discharge across a range of pathways.

In 2022/23 we saw an increase in discharge to assess placements to residential care some of which inadvertently led to permanent placements. A review of discharge to assess process is underway as there needs to be further understanding of the impact of discharge to assess on the decision to make the placement permanent.

For 2023 there will be an increased focus on our Home First model, home based reablement services and Support at Home in which care providers deliver blended roles carrying out some low level health functions that individuals and family members are often shown how to do. Tameside has been a trailblazer in successfully rolling out this model across its neighbourhoods.

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.

The services we commission provide good quality, joined up care which supports people to stay well, for longer, at home and have access to good quality advice and support in their community. When people do require hospital care, that care is safe and effective and they have a positive experience. Integrated commissioning and delivery has been in place in Tameside for some time. The newly established models around strategic design and operational design and delivery help to further support this model with clear governance and responsibilities.

Our local right care, right place model encourages residents to access care in the most appropriate setting for their needs. We have worked with partners to create a communications campaign that endorses this approach and support self-care and patient choice.

Home First

The trust has as well established Home First Pathway in place to support patients to be discharged on the day that they are medically optimised to receive their assessment and identified health and care needs met in their own home.

The IUCT team provide a 2 hour response for Home First Discharge. The challenge to the system is that demand currently outweighs capacity. This results in patients being at greater risk of being stranded in hospital awaiting assessment and domiciliary care to be put in place prior to discharge.

Increasing the availability of care hours available in the IUCT team will increase the amount of patients who can be discharged to home without delay which will support the objective of the BCF to promote greater bed availability within the hospital setting.

The Tameside Home First model does not only support a reduction in delayed transfers of care the integrated multidisciplinary team provides greater capacity for patients whose longer term needs may have been assessed as best met within a residential setting being given the opportunity to have intermediate care provided in their own home prior to making a life changing decision.

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, i.e. 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 – e.g. 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 plan as a result of this work.
    - 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.

Year End Summary 22/23

During 22/23 the system applied a key focus on hospital avoidance for our frail eldery residents by implementing our Acute Frailty Service. This service provides early proactive identification and subsequent management of over 65's with acute frailty syndromes to avoid admission in the first place or early discharge where admission is required. This service will be continued during 23/24.

Robust executive oversight has seen the numbers of delayed discharges consistently reduce during 22/23 this achieved thorugh a system wide improvement programme (see National condition 3 for more information.

However we have also continued to see some challenges in the numbers of people discharged to residential care and therefore a review of D2A pathways is a key priority for 23/24. The outcome of this work my result in a reprofiling of spend against the discharge pathways to ensure that residents receive the right care in the right place at the right time.

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 metrics:

- Discharge to usual place of residence

Expansion of Frailty SDEC to an Acute Frailty Service

Local Drivers – Our aging population:

There are just under 40,000 adults aged 65 and over living in Tameside (39,976) and a further 45,878 adults in the 50-64 age range.

In relation to projecting the older population of Tameside over the next 21 years, the over 80 year old and over 90 year old population is expected to increase by 69% and 92% respectively. The over 65 population is also expected to increase by nearly 20%. This is in contrast to other age groups which see much smaller growth.

The levels of disadvantage and socio-economic deprivation, as measured by the Index of Multiple Deprivation 2019, show that Tameside has relatively high levels of economic disadvantage across the community as a whole and falls within the group of Local Authorities that are the most disadvantaged in England.

One of the most striking differences between Tameside and its comparators is the proportion of adults aged 65+ that live alone. This is especially important for ageing because social isolation, loneliness and higher levels of deprivation are associated with living alone in later life, alongside worse mental and physical health.

The overall health of adults aged 65+ living in Tameside is largely worse than the rest of England, with significant health inequalities affecting the adult population in this age range. The data relating to this age group suggests that ill-health and disability, or the factors that lead to them, are perhaps already well-established by the age of 65 for many adults in Tameside.

Local data demonstrates that adults over the age of 65 have joint health and social care needs highlighting the importance of a CGA to identify and address areas of concern at the earliest opportunity to achieve better outcomes.

Tameside local data demonstrates that an Acute Frailty offer is paramount in our locality even more so that others considering our ageing and complex population.

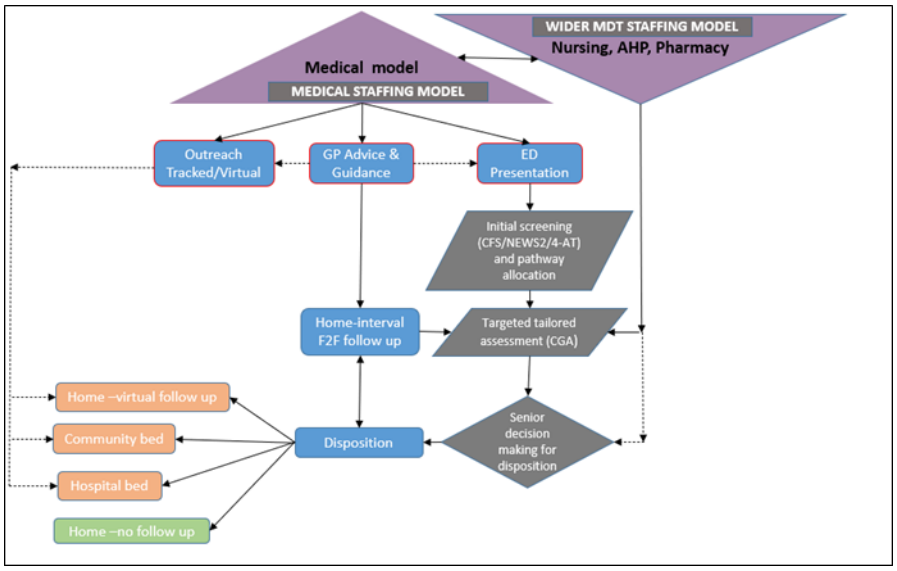
Acute Frailty Service

The aim of the Acute Frailty Service is to achieve the national standards for frailty and to locally close the gap in terms of outcomes for our aging and vulnerable population.

The vision for the Acute Frailty Service (Diagram 1) is to avoid unwarranted hospital admission for older people presenting with acute frailty syndromes, and to reduce their length of stay where admission does occur.

It seeks to achieve this by providing:

- Early proactive identification and initial assessment and management to older (aged 65 and over) patients presenting to SDEC/ED with acute frailty syndromes
- Advice and guidance to GPs and 111
- Tracking and promoting early discharge for eligible patients who require emergency admission on a shared care basis.



The acute frailty service is designed to avoid admission to hospital where a patients needs can safety be managed in the community setting and where admission is appropriate that the team facilitate discharge at the earliest opportunity avoiding prolonged hospital stay.

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.

Executive Length of Stay and Patient Flow Improvement Board

The Director of Adult Social Care and Chief Operating Officer jointly chair the executive length of stay meeting.

The meeting serves two purposes; to minimise the number of patients with no criteria to reside in Tameside and Glossop NHS Foundation Trust and drive transformation and efficiencies to improve transfer of care.

Currently the Executive Length of Stay is monitoring a number of improvements that are reported weekly, these include:

- Step up to Intermediate Care from Community Based services.
- Development of an education programme for hospital-based staff on the community offer.
- Develop a process for positive risk management around discharge from hospital.

- Develop detailed sitrep for social care and community services (linking into capacity meetings)
- Admissions avoidance – Expansion of services and opportunities.
- Expand the Home First Model across Tameside and Glossop.
- Reset capacity in IUCT to respond to Home First Tameside Discharges.
- Agree and implement a Trusted Assessor Model
- Implement a process for MDT system-wide Harm Reviews for all delayed discharges
- Agree the preferred reablement model to meet the needs of the system

The key driver of the executive led length of stay meeting is aligned to the national conditions of the better care plan ensuring that integrated working is central to transformation. The transformation schemes listed will be central to enabling people to stay well safe and independent at home for longer and ensure that care is provided in the right place at the right time.

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?

During 2022/23 the BCF plan was reviewed in line with the governments 10 year Strategy for care and support 'People at the Heart of Care', the Tameside locality plan and a shared vision to ensure that:

- People have choice, control and support to live independent lives
- People can access outstanding quality and tailored care and support
- People find adult social care fair and accessible

Tameside Adult Social Care 'Living well at Home' model ensures that enabling people to live at home for as long as possible is central to the care and support offered. Following a successful pilot in the summer of 2019 and a delay during the pandemic, the 'blended roles approach' is now embedded across all the zoned support at home providers and a handful of care homes, and has been recognised Nationally within the 10 year strategy for Adult Social Care 'People at the Heart of Care'. The approach, in essence, means that a number of low-level health care tasks that district nurses do, but you don't need to be a district nurse to do are delegated to care workers. Delegation is the process by which a registered nurse allocates the task to a named, competent, non-registered practitioner. The registered nurse is then accountable for their decisions to delegate tasks and duties to other people whilst remaining responsible for the overall care of the service user.

In practice, the main tasks have been pressure area care and insulin administration. The approach is based on refresher training for care staff followed by training and competency sign off for the care needs of an individual service user by a named care worker. Training and competency sign off is undertaken by the Blended Roles Facilitator, a district nurse by profession. The approach delivers a number of key outcomes:

- Improved continuity of care for the service user along with improved health and wellbeing
- Fewer knocks at the door for that person
- Improved communication between providers and DN's facilitated in part by weekly team huddles, but also via the Facilitator role
- Closer integration; the providers are valued as recognised members of an integrated neighbourhood approach
- Helps providers with recruitment and retention of staff
- Career progression; care work as a stepping stone to nurse or social work training
- Frees up DN capacity; hours repurposed working with more complex patients

As of January 2023:

- Approx 140 support at home staff trained in pressure area care with 42 staff signed off as competent to work with named individuals, freeing up approx. 13 hours per week of DN time
- Over a hundred care staff trained in insulin administration with 25 staff subsequently signed off as competent to administer insulin to ten people freeing up in the region of 26 hours per week of DN time

Trusted Assessors

Support at home providers routinely undertake 6-weekly and 12-monthly reviews of all the people they support; most undertake quarterly reviews in-between. This ensures people are receiving the level of support they need to maximise independence whilst also ensuring that providers can utilise their full capacity to pick up new POC's. One of the zoned providers notifies their neighbourhood when reviews are due allowing social workers to attend by way of meeting Care Act requirements. The intention is to refine this approach and roll out a Trusted Assessor approach to reviews across all four neighbourhoods in the coming months.

Care Sector Quality Improvement Team

The QI Team funded through BCF currently consists of social workers, nursing staff and medication management support.

Over the last 12 months the QI Team have provided numerous awareness sessions to care home staff re: pressure care, manual handling and mental capacity as well as medication audits. The team have been actively involved in supporting seven care homes who were/are under Tameside's new Escalation and Accountability Framework, as well as providing supportive audits to other care homes. The QI Team links closely with the Council's Commissioning Team to co-ordinate support to those care homes that would benefit the most.

As a result of the ongoing work of both the QI Team and the Commissioning Team over the last financial year, the CQC published ratings for care homes have improved from 84% rated 'Good' or 'Outstanding' to 89% 'Good' or 'Outstanding'.

See also Community Response service -National condition 2

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.

The BCF supports unpaid carers by providing for a Carers team and associated program of activity as part of Tameside's Carers Strategy. A recent national carers survey shows that carers have felt more isolated as a result of the pandemic and so as part of recovery a strategy refresh is underway along with a revised programme of carers support.

Recently commissioned research with unpaid carers across the district explored the carers' general experience, the challenges they face and their awareness, and use, of support services. This to understand their experiences and challenges and day-to day impacts in their caring role and inform the development of Tameside's Carers Strategy which will be published in Autumn 2023. Support for unpaid carers is a key priority in the locality ASC plan and as such funding has been prioritised to ensure a 'core offer' of activity and support which a Carers Team oversees.

<u>Carer Offer</u>

All carers in Tameside are offered a Carers Assessment, following which we complete a support plan that is tailored to the individual needs of the Carer with a focus on their wellbeing. We offer a radar key, message in a bottle and Tameside Emergency Card (TEC) card along with any resources/information, signposting that is identified at assessment. Assessments are offered in a format that works for the Carer, this could either be telephone, home visits or in one of our Hubs.

There are currently five 'Hubs' up and running in the localities, to support Carers to access support in their local area if they are unable to come to Ashton for their appointment. We run a range of activity for carers (peer led and informal meetings) for Carers to drop in and meet other carers/reduce isolation/improve wellbeing that include (but not limited to):

- daily drop-in to see a Wellbeing Advisor to register as a carer, get emotional support etc.
- Peer led coffee mornings once a month
- mini market place with CRS who is available to talk to Carers about alarms/pendants for the cared for
- topic related training for carers such as support for those caring for people with Dementia which is delivered in partnership with other agencies or voluntary sector
- Carers team staff attend local networking events, coffee mornings to develop outreach opportunities in the community.

*TEC card – gives piece of mind that if something unexpected happens to the carer, such as an accident or sudden illness, help can be arranged for the person you care for as well by contacting the Tameside 24 hour emergency contact number.

*Message in a Bottle – small bottle containing all my medical and health needs for the cared for and can be the carer, the kit comes with a sticker that you put in the window so that any emergency service know there is a 'message in a bottle'

Disabled Facilities Grant (DFG) and wider services

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

Tameside Council recently launched its Housing Strategy 2022-2026. Our priorities are firmly established through our corporate plan, 'our people, our place, our plan' where housing plays a central role in achieving our vison to enable people to start well, live well and age well. Good quality housing is a vital part of creating and sustaining neighbourhoods that can support wider social change, inclusive economic growth and community wellbeing.

Our priorities for people drive how we approach solutions:

- Providing the right support, for the right person at the right time and reduce the use of residential care and inappropriate admissions to hospital.
- Supporting people to remain living in Tameside or return to Tameside.
- Enabling people to live in their own home, if possible, or for as long as possible.
- Ensuring that people live independently in their home and interdependently within their neighbourhoods.
- Creating choices about where people want to live, how they live and whether they rent or own their property.

There are approaching 100 households on the disabled housing register who need alternative or new accommodation in Tameside. Many of their homes cannot be adapted to meet their needs and we know we need to find alternative accommodation.

In many of these households care and support is provided by family members and the whole family need a new home. We will work on an individual basis to support these families into new homes and develop a pre-nomination's agreement for affordable homes so that adaptations are built into new homes bespoke to individual household needs.

We will also be promoting products that support households to find a more appropriate home so that people can continue being cared for at home and living as independently as they can.

We will continue to be innovative with our funding sources; developing specialist accommodation support for people with specific needs such as using Better Care Fund (BCF) Disabled Facilities Grant (DFG) funding flexibly to better meet the needs of our residents. For example A range of project have been agreed through the DFG which provide a range of lifting equipment to our support at home commissioned services with the aim of reducing ambulance call outs and hospital admissions.

Please also see next section for more information

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? (Y/N)

The Council has a current Housing Financial Assistance Policy developed under the RRO. This Policy was introduced in 2018 and is undergoing a review to develop the Policy for the next 5 years.

The current active RRO Policy includes a number of discretionary grants to deliver adaptations without the need for the applicant to undergo the requirements of the mandatory grant. We have introduced: a discretionary grant where the applicant is not required to undergo a test of resources for works up to a max cost of £7,000 to reduce paperwork and speed up delivery;

- A prescription grant for lifting and hoisting equipment and special toilets to speed up delivery and where no formal application or test of resources is required;
- A hospital discharge grant to deal with property conditions (deep cleaning/ hoarding, small building repairs related to health and safety issue, etc.);
- Relocation grants for owner-occupies and tenants where adaptations are not appropriate; discretionary grant to assist with unforeseen works and contributions on approved DFG works.

As part of the discretionary grant options we also have introduced two non-adaptation grants:

- A Staying Put grant for home owners over 65 years who require essential repairs to their property.
- A home Repair grant for other vulnerable home owners where essential repairs are required.

The purpose of these grants is to arrest deterioration in a property that may lead to health issues for the occupants, thereby avoiding the need to call upon health services and/ or to reduce the need for other medical attention.

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

There is no specific amount allocated to the initiatives that relate to adaptations because the decision to use the various discretionary grants is taken to ensure maximum benefit is delivered to the applicant. The offers are across the whole borough.

The discretionary grant for Staying Put and Home Repair applications is limited to approx. £0.150m per year. The offers are across the Tameside locality.

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? 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 in line with Core20PLUS5.

The wider determinants of health are a diverse range of social, economic and environmental factors, which influence people's mental and physical health. Variation in any of these factors constitutes social inequality, and in turn therefore drives health inequalities.

Like many areas across the UK, Tameside experiences health inequalities that disproportionately affect certain population groups. Some examples of public health inequalities in Tameside include:

- Deprivation: Tameside has higher levels of deprivation compared to the national average, and people living in more deprived areas tend to have poorer health outcomes. For instance, there are higher rates of smoking, obesity, and mental health problems in more deprived areas of Tameside.
- Ethnicity: There are significant health inequalities between different ethnic groups in Tameside. For example, the South Asian community has higher rates of diabetes and cardiovascular disease compared to the white British population.
- Age: Older people in Tameside may face health inequalities due to social isolation, lack of access to health services, and age-related health problems such as dementia.
- Gender: Women in Tameside may experience health inequalities related to reproductive health, with higher rates of teenage pregnancy, cervical cancer, and breast cancer.
- Disability: People with disabilities may experience health inequalities related to access to healthcare, social support, and employment opportunities.

Addressing these inequalities requires a multifaceted approach that addresses the underlying social determinants of health, such as poverty, housing, and education, as well as improving access to healthcare services and promoting healthy behaviours.

Aside from health inequalities across Tameside some of the biggest public health challenges include:

- Obesity: Tameside has a higher-than-average obesity rate, with approximately 1 in 3 adults being classified as obese. This can lead to a range of health problems, such as diabetes, heart disease, and some forms of cancer.

- Smoking: Despite a decline in smoking rates across the UK, Tameside still has a high proportion of smokers. Smoking is a leading cause of preventable illness and premature death.
- Mental Health: Tameside has higher than average levels of depression and anxiety, and there is a growing concern about the mental health of young people in the area.
- Alcohol Misuse: Tameside has high levels of alcohol misuse, with associated problems such as liver disease, cancer, and mental health issues.
- Poor Air Quality: Air pollution is a significant public health problem in Tameside, with the potential to cause respiratory problems, heart disease, and other health issues.

All services and pathways commissioned accessible via Health services are free at the point of access and are embedded within communities/neighbourhoods.

Social Care provision where applicable is needs assessed in line with National guidance and therefore it is expected that the application of these guidelines does not disproportionality effect any specific population group.

Services provided/enhanced through BCF are based on professionally assessed need and engagement with the locality 'system' to access these services with personalised needs considered, recorded and agreed with our population and shared with the appropriate services.

All projects relating to commissioned services are subject to Equalities Impact Assessments to outline the impact any decisions or policy have on those with protected characteristics, with the purpose of identifying and mitigating any adverse, unintended consequences of decisions and changes. One additional area which has been added to this range of protected characteristics, which are covered by the Equalities Act, is socio-economic duty, which is an additional area of consideration, linked to the socio-economic duty.

From a strategic perspective, Tameside's Health & Wellbeing Board has been assigned as a standing commission on inequalities to ensure that tackling inequalities remains a focus across the system and within all identified priorities. This is one of the core principles of the Health & Wellbeing Board Charter and particularly cuts across the priorities of the Health & Wellbeing Board around poverty; work & skills; and healthy places.

The principles around tackling inequalities are reflected in the integrated working across the system in the new structures. One of the workstreams across the transformation programme, which reports into the Tameside Provider Partnership, is around transforming long term health, with a focus on long term conditions. Some of the greatest outliers and worst outcomes can be seen in the borough's more deprived neighbourhoods and among some of our communities, particularly ethnic minority communities, which highlights the role that inequalities play in this. Therefore a focus of this work is around working with communities differently with work commissioned to co-produce different approaches to engaging with residents around health seeking behaviour and engaging with healthcare around key risk factors such as NHS Health Checks, blood pressure, atrial fibrillation and diabetes. This work has closely aligned to the Core 20 Plus 5 principles and incorporated some of the priority 'Plus 5' categories, as well as working closely across primary care to also address variation in service delivery and access.