

North East Lincolnshire

Better Care Fund

Narrative Plan 2021/22

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

How have you gone about involving these stakeholders?

in addition to sharing the draft plan with key individuals across health, care and housing, the plan has also been shared with:

- the integrated Care Partnership (ICP) leadership group
- Sector Support
- Centre4
- Community Forum
- Healthwatch
- Multi-agency winter planning group.

The plan was supported in principle by the Union Board on 16th November 2021. Sign off via the Health and Wellbeing Board is expected on 22nd November 2021.

Executive Summary

This should include:

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

North East Lincolnshire's (NEL) approach to health and wellbeing, focusing on prevention, putting the community at the centre of service re-design, and supporting people to take more responsibility for their wellbeing, is represented in the 'funnel of transformation' depicted in previous BCF plans. This focus on community-based prevention remains key to current and future planning.

The Adult Strategy (applicable to all adult health and care services) referenced in our 2019/20 plan remains in place and sets out our person-centred, enabling, approach. By focusing on individual and community assets and strengths, we aim to increase the likelihood that we will create a resilient population able to thrive on independence and self-care, and reach their maximum potential. However, this aspiration has been particularly challenging during the pandemic. The priorities set out within the Strategy continue in the current year, although it has not been possible to progress in all areas at the speed or in exactly the same way as envisaged before the pandemic.

Across the system, it has been necessary to re-prioritise, and spend a great deal of resource on:

- Ensuring those most in need continue to be appropriately supported, including by mobilising volunteer services to support those defined as most vulnerable
- keeping oversight of quality across the health and care marketplace, ensuring continuity of and access to services
- Overseeing workforce issues (training, isolation, cohorting, absence/ low capacity) and ensuring access to PPE and other necessary equipment
- Developing and implementing business continuity plans and seeking assurance in relation to providers' plans
- Implementing financial market support mechanisms to avoid market failure, and administering grant funding to around 70 providers

- Responding to, and implementing a raft of regularly changing government guidance (infection control, support to care homes, winter plans, PPE, care home visiting, day care, Care Act easements, hospital discharge)
- Developing new systems of reporting (e.g., capacity tracker), reporting on implementation of the raft of guidance, monitoring and reporting on grant spend.

These are areas in which we wish to make further progress to achieve our priorities:

- Our information and advice framework/No Wrong Front Door approach has somewhat stalled (though a new single point of information is complete)
- Our work on considering the interface between services and coordination of assessments has not progressed at an equal pace in all areas (though there is some improvement in the link between children and adult services, and between housing and wider adult services)
- Our reablement review has not had the desired scope or attention (though pandemic exigency has created improved step up/ down provision as part of the intermediate tier)
- Work to ensure targeted data collection across the Union has taken longer than anticipated (though it is now renamed 'insights NEL' and being led by a designated group)
- Mechanisms for oversight of the Adult Strategy have not yet been formalised (though the action plan has continued to be refreshed)

Governance

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

As noted in our previous plan, individual schemes are subject to regular monitoring and/ or are monitored by a scheme board or steering group, comprising professionals and community members. This means evaluation is on-going as part of 'business as usual', rather than a one-off activity for the benefit of our BCF plan. Any underperformance is addressed via the relevant board/ steering group or contract monitoring meetings. BCF programme governance is part of overall partnership governance that exists to support the Union. Pooled budget managers are the CCG's Chief Finance Officer and the Council's Director of Resources and Governance. The overall lead for the plan is the director of adult services - a joint post across the Council and CCG. On-going high-level oversight of BCF schemes, and development of BCF plans, is undertaken by the BCF steering group (comprising CCG and Council staff) which reports to the Union's joint senior team and the Union Board. The Union Board in turn reports to the Health and Wellbeing Board.

To facilitate informed governance and support us in identifying outcomes and user experience (including in respect of BCF schemes), we continue to work to create a comprehensive view of adult services performance. Our ongoing performance review is running in tandem with wider Union work to create a performance framework which measures against the five place-based outcomes (adult services' performance feeds into the health and wellbeing outcome), seeking to evidence the Union's added value for the entire local population- including those living in disadvantaged areas. Data collection in some service areas has improved significantly as a result of the pandemic, but wider place-based data collation and analysis work is not yet concluded. This is needed to ensure that governance mechanisms are supported by accurate evidence.

SIGN OFF OF PLAN: the draft plan was supported by the Union Board on 16th November 2021, pending final sign off by the Health and Wellbeing Board on 22nd November 2021.

Overall approach to integration

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

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

a) Joint Priorities

This section of the plan sets out priorities and notes changes when compared with narrative offered in previous BCF plans.

The Adult Strategy, which focuses on health and care services but seeks to influence wider services which support wellbeing, remains the backdrop for local prioritisation. It sets out how the ambitions of the local outcomes framework, and place-based vision for health and wellbeing (also referenced in our previous BCF plans), can be delivered by adult services.

Information and advice and the Single Point of Access (SPA)

The launch of the Livewell site last year, which replaces services for me and now acts as our single point of information (referenced in our previous plan), enables professionals and local people to access low level support to help themselves. The Livewell site - <https://livewell.nelincs.gov.uk/> - will continue to be developed during this year. To date it includes a self-assessment tool which offers specific tailored advice or enables results to be sent to the SPA for telephone contact to be made. In addition, there are specific portals of information relating to dementia, sensory impairment and carers. The Livewell site is integrated with another digital platform, Simply Connect - <https://nelincs.simplyconnect.uk/> - offering advice and information on community resources and activities such as 'knit and natter'.

Our 'front door' is a focus for continuous improvement, building on efforts to assess the impact from engagement at the SPA. The SPA continues to offer integrated health, mental health, social care and therapy access for professionals and the public within NEL. It has been pivotal during the pandemic, working collaboratively with the Council's contact centre, enabling co-ordinated multi-disciplinary responses to callers. To date in 2021/22, calls have averaged at 13, 851 per month across all disciplines: an increase of approximately 11% from 2019/20.

Priority: ensure our integrated information and advice offer (Live Well), and engagement via the 'front door' (SPA), is person-centred, and focused on promoting independence.

Housing based help

Care home provision and support to care homes

As a result of the fall in demand for residential care during the pandemic our local market has weakened. Two care homes have closed, and one has temporarily closed in the interim, reducing the number of bedspaces by 96. However, this still represents more places that are needed by commissioners. We recognise the need to change our approach to care home commissioning and contracting. We will begin this process following the update of the market position statement.

We have made progress in a number of areas. All residential providers met the required contractual standards and are on the new rate i.e., the rate agreed via our cost of care exercise. The capacity tracker and adult care dashboard provides up to date monitoring information and weekly webinars provide a discussion forum to clarify practice issues. Weekly and sometimes daily contact is made with providers regarding on going assurance and advice via the contracts team.

Processes are established for regular review and assurance regarding all elements of support to care homes. A working group is focused on ensuring that multi-disciplinary support teams are engaging, via linked primary care networks and GPs, to ensure the best quality health and care delivery within settings. Part of this work will help homes to support people with more complex needs following discharge from hospital, and some of the work will aim to prevent hospital admissions.

We provide an enhanced nursing support offer to care homes, as well as providing each home with training in infection control and use of PPE, followed up by regular contacts to maintain those skills. Care homes have been provided with equipment and training to undertake basic observations. We are also training care home staff to recognise deterioration in residents' health, supported by a clear process for raising these concerns with the GP. The CCG director of nursing leads on an area of the public health outbreak plan which focuses on the enhanced nursing offer to care homes and on nursing leadership in and out of hospital, as well as leading for the health and care executive across the whole system on workforce response during escalated COVID19 cases and how we support the system, including care homes.

It remains our intention, as set out in previous BCF plans, to progress extra care housing (ECH) schemes as part of our accommodation with care offer. Our plans to develop such schemes have generally been behind schedule, but are making progress, as follows:

- Burchester Court (Winchester Avenue) was completed during the pandemic and we successfully moved people in under COVID restrictions, offering 60 further modern, adapted self-contained units. This means that we now have two fully functioning ECH schemes (the other scheme being Strang Court, previously reported on)
- Davenport Drive (former Matthew Humberstone school site) – we are now grappling with the shape of the site and negotiations regarding the land value. This scheme should offer between 70-90 further units
- Cambridge Road (former Western School site) – site evaluation is starting. It is hoped this scheme will also offer between 70-90 further units.

Both Davenport Drive and Cambridge Road form part of wider housing development schemes by the Council. Agreement from Sports England has been granted (as these were both old school sites, with playing pitches) to use the land for ECH, and we are now seeking interested registered providers to act as housing provider; the providers will form part of the team that designs more detailed plans of the buildings themselves.

Priority: ensure our housing-based help offer is a) sustainable, b) supported by appropriate professional input, c) sufficiently diverse to meet the needs of local people and enable independence.

Care at home

We implemented our new support at home model based on “teams not times” and are developing the impact/ user outcome measures as part of the planned work that followed the tendering process.

Evidence suggests that the just checking scheme – which offers additional flexibility to our care at home model - continues to offer cost avoidance by avoiding attendance at hospital, respite admission and unnecessary use of other community services. This responsive service provides improved qualitative benefits for service users by being personally centred to their immediate needs. Support at home staff benefit from the flexibility of being able to respond effectively to support the individual. This service supports people who have multiple health and care needs when most in need of temporary support and don't have alternative support available. Building on the learning from just checking continues to inform ongoing development of our support at home model. Through working differently with our support at home providers we make better use of the care and support staff working within the community and ensure that the service overall is more productive, focusing effort on outcomes rather than the traditional time and task model.

During the pandemic, we were not successful in recruiting therapy support to enable us to progress our accompanying single-handed care initiative. This is designed to improve the efficiency and effectiveness of care at home services, by reducing the number of calls reliant on two or more care workers. This enables more agile care rostering and improves services capacity and responsiveness. We have recently recruited to the posts that are needed and will now be able to progress this work.

The care at home market is currently experiencing multiple, nationally well-rehearsed challenges. However, our intention remains to deliver an enhanced service as well as additional capacity in our care at home service to ensure a 'home first' approach, reduce the reliance on short stay residential placements and protect and preserve the more limited reablement bed-based capacity.

Priority: appropriately resource and embed new support at home model to ensure personalisation and promotion of independence is maximised (evaluated using Making it Real Framework).

Reablement

Creating additional reablement capacity (step up/step down) remains a focus of activity during 2021/22. Plans to bolster bed availability at Cambridge Park and intermediate care at home are especially challenging, as both services have lacked staff capacity for a prolonged period.

Cambridge Park enhanced recovery unit was commissioned during the pandemic in 2020 to provide 50 beds to replace the smaller and outdated facilities at the Beacons (intermediate care/ discharge to assess setting). We intend to widen the scope of services to accommodate new needs such as plus size care and improve stroke recovery. Cambridge Park has not yet operated at full capacity and due to limitations during the pandemic in being able to recruit and retain a number of suitably qualified staff, building suitability, outbreaks and most recently a CQC report requiring further improvements to be made. The site is currently offering 32 rehab beds.

The reablement improvement programme will run over several years; the priorities include;

- Increasing the capacity within our intermediate care bed-based facility (Cambridge Park, as above)
- Enhancing the offer within intermediate care to include enhanced nursing functions for e.g., intravenous therapy
- Block booking additional enhanced recovery beds to support discharge and avoidable admissions
- Reviewing the demand and complexity of need for intermediate care at home provision compared with capacity and developing a model fit for the future
- Creating a re-ablement culture across NEL
- Launching the singlehanded care initiative (see care at home section above).

Community re-ablement support is also an ICP priority. An early discussion has been held to identify project management arrangements and agree support to deliver the programme of work.

The Council and CCG have been working with the Assisted Living Centre (ALC) to improve the performance dashboard and financial monitoring of the service. The service has moved onto a new version of the BEST system which will allow for easier reporting and monitoring of the service. Work has progressed to explore the equipment required to support the single-handed care agenda and provision has been made available within the service to support this. The ALC continued to deliver aids for daily living and wheelchairs to meet need throughout the pandemic. Work recently commenced to improve the out of hours repairs service, and a new provider has been commissioned. Work will continue during this year to ensure the specification is fit for purpose and that the KPIS demonstrate the service quality and delivery of user outcomes.

Priority: ensure effective delivery of reablement provision and wider services which support it (e.g., the ALC), whilst working to embed a 'reablement culture' across all levels and types of support.

VCSE (voluntary, community and social enterprise)

Joint working with the voluntary sector has been crucial in meeting local need throughout the pandemic. Building on that, we are working closely with the sector to ensure that the wellbeing hub (Connect NEL) development is part of our preventative offer. The wellbeing hub will enable signposting to sources of support and will focus on stimulating community action and involvement to prevent loneliness and social isolation. There is scope for this to be an all-age approach. We estimate that for every £1 spent, £12 in costs to the system can be avoided.

This year the Preventative Services Market Development Board (PSMDB) has continued to develop an approach to the development of community-based initiatives that can impact health and social care issues, based on the success of previously funded projects. The PSMDB has assessed the projects that have delivered the most impact for the investment provided and used Social Return on Investment to undertake cost/benefit analysis. The Board concluded that investment into community hubs provided an optimum return. These are located across the borough in carefully targeted community settings, offering a wide range of activities and services. The PSMDB has also created added-value projects to existing services, including a community handyman service, gardening service and enhanced meals on wheels service.

Although Covid-19 has had a significant impact on the Board's work, and progress has been hampered, work has continued as follows:

- | | |
|------------------------------------------------------------------------------------------------------------------------------|-------------|
| ○ Total value of Awards | £35,000.00 |
| ○ Additional Funds levered into the health and social care sector | £202,700.00 |
| ○ For £10 spent by PSMDB, it has attracted a further
(in organisations' own contributions and external funding attracted) | £57.91 |

Priority: work with VCSE colleagues to ensure coordinated and accessible preventative opportunities, and use existing mechanisms to support projects designed to achieve the same.

Workforce development, assessments and interface between services

NEL has been promoting and embedding an asset-based approach to practice for some years. All staff micro-commissioning placements (social work, mental health, continuing health care and community nurse practitioners) are expected to work under the local ethical and pragmatic decision-making policy. This is our micro-commissioning framework which advocates an asset-based approach, and is reflective of the national ethical framework published during the pandemic. The asset-based approach is also embedded in the SPA. The framework has recently been updated, and

an accompanying programme of public engagement and practice development work will be rolled out this year. This will complement existing programmes of engagement and practice development noted in previous plans. Practice development events this year (offered to all commissioner and provider staff across health and care) include sessions on:

- the Mental Capacity Act 2005 (MCA) and its implications for people of faith, and none
- the MCA and its implications for people with learning disabilities
- the MCA and working with those who refuse, or object to, health and care
- the interface between the MCA and Mental Health Act 1983.

This programme of events also supports us in work to address inequalities (see section 6 below).

A number of work programmes are in place to improve practice at the interface between services, such as that between children and adult services (both health and care). The preparation for adulthood working group has supported the refresh of the preparation for adulthood protocol, the launch event for which is intended to take place later this year. The protocol is accompanied by an action plan against which some progress has been made, although there is much more to do.

The working group, drawing on evidence from transition audits referenced in our previous plan, has highlighted the need for a more effective strategy for managing younger adults. This includes the need to foster consistency of assessment and care planning practice across children and adult services – including in particular, securing greater value from review processes, to ensure that individual outcomes are clear and focused on promoting independence across the life course. We are also working to develop a joint commissioning strategy for complex younger people with long term care needs.

With regard to housing, there is significant engagement and improved methods of working, that pull together both the strategic, enforcement and home options teams in the Council as well as teams in the CCG. This positive interface between services is beginning to deliver a pathway to address previous weaknesses. Work will continue to shape the pathway, supported by agreed principles for shared working. Housing plays a key role in complementing the delivery of the BCF.

The Strategic Housing Action Plan provides clarity around key housing challenges. It sets out four key interdependent themes including housing's contribution to improving health/ wellbeing. The Plan includes building closer working relationships with adult services and other appropriate adult care agencies, promoting health and welfare, building independence and resilience and opportunity related to housing, and sharing resources to deliver positive housing outcomes for adults.

Priority: continue with the programme of work focused on ensuring staff identify individual outcomes and the progress towards meeting those outcomes, across the life course and across services.

Collecting information

The multi-disciplinary Insights Group (core project group) has clarified the purpose of this work:

- To ensure we know what data and information we hold, (and gather) where it is, who is responsible for it and what we can do with it
- If we bring together the right information (all of it) at the right time, we can define the insights we need to make a positive impact on our planning. This, in turn, will improve the lives of people within NEL
- We will use this information to understand key issues. Listening to local people will put us in a better position to help them and to deliver messages to them in the right way.

Over the summer we have been working to fully assess the current picture of how we hold, engage and receive qualitative and quantitative information in NEL focusing first on Council and CCG

processes. The work has already linked with ICP development. During autumn, we are working in partnership to theme and draw insights from the information we have gathered and hope to prove some of our early assumptions. We will identify opportunities and potential solutions, and then reach out more widely with VCSE and partners across NEL to test ideas. As we move into winter, we hope to be able to pilot some of our shared solutions across the Council/ CCG. Whilst some change may be quick, the overall programme of work will be ongoing; for example, testing ways of gathering staff and community voices will take time.

Priority: develop a comprehensive Union approach to insights which allows effective targeting of resources and greater benefits for the residents of NEL.

b) Approaches to joint/ collaborative commissioning

All service areas in this plan are commissioned by the CCG on behalf of itself and the Council, or vice versa.

c) Approach to maintaining independence

The Adult Strategy is about how health and care services/ support will work together to help local adults to enjoy our vision for health and wellbeing. The vision is: “Adults in North East Lincolnshire have healthy and independent lives with easy access to joined up advice and support which help them to help themselves”. This vision can be described as a ‘promoting independence model’. This means that our support offer is designed to work alongside the person, to find ways of helping them that maximises opportunities for greater health and independence, and minimises the need for help. Support for adults will be reablement based, challenging people to do more for themselves, and consistently reassessing their ability to maintain, gain or regain skills wherever possible. We define our success by how far people have been re-abled (helped to maintain, gain or regain their health and independence, as much as this is possible for them).

Recent input from Impower (which helps public services to produce lasting, positive change in complex systems) has highlighted that there is more work to do in our areas of priority, if we are to make progress greater on promoting independence. The narrative above in respect of priorities is guided by our approach to promoting independence; two further examples are given below of on-going work designed to improve the promotion of independence:

- Direct payments: following public and professional consultation in autumn 2020, our direct payment offer is being revitalised. Our integrated offer applies to adult social care, continuing health care and provision under s117 of the Mental Health Act 1983. We have invested in a direct payment card account system and are in the process of transferring (where possible and appropriate) existing direct payment accounts to that system. It is anticipated that this will make direct payments easier for service users and professionals to manage, and so more attractive as a means of promoting greater independence. Our direct payment policy has been relaunched. This is accompanied by a programme of practice development to ensure that clear operational processes are in place to support practitioners to promote direct payments as a tool for independence, where appropriate
- We are undertaking a review of our day opportunities offer. Engagement with users of day services and service provider organisations will enable us to gather information about current services, and assess the degree to which such delivers on the Adult Strategy’s vision. The review is essential to ensure that people’s needs are being met through the opportunities provided; services should provide access to social activities, help individuals build skills and confidence, develop relationships, and maintain their independence. The review will include consideration of equality and diversity issues. Findings will be published early in 2022, and will be utilised to inform next steps.

During 2021/22, the offer of extended access to general practice Monday to Friday 8am to 8pm and weekend opening has been reinstated, following the initial pandemic response which necessitated use of those resources to support covid services. The service is now back up and running and continues to be delivered on a collaborative basis by local practices working together with Primary Care Network (PCN) groups. This is currently in place until the end of March 2022, when it is anticipated that there will be a new service specification issued by NHS England (NHSE) which will form part of the PCN national enhanced service contract requirements.

NEL continues to work collaboratively with local VCSE organisations to deliver a successful social prescribing programme. This has been further expanded during 2021/22 through the existing service and the PCNs working together to integrate the PCN social prescribers, recruited through the national PCN funding, to work alongside the existing staff but with a named lead for the PCN population. To date, numerous patients have benefitted from activities to help them manage their long-term conditions more effectively.

d) BCF and integration

So far as legally possible, the CCG and Council have achieved integration via a Union, and this has been reflected in further updates to the s75 agreement which has been in place since 2007. The CCG and Council continue to be co-located so that health, care and public health commissioning teams work in the same building and are led by a joint management team and chief executive. A single Union commissioning plan has been developed, underpinned by a set of shared core commissioning principles designed to reflect the findings of the Adult Services Review (referenced in our previous plan), aligned with our Adult Strategy. The Union has been supported to develop further by FutureGov, via an integration road map which sets the standard for decision making, culture, and organisational design. Local teams are taking this work forward, to ensure the Union's vision is realised: "to grow and enhance the place of NEL to improve the health, care and life experiences of our population".

Digital enablers of integration

As well as continuing the digital work outlined in our previous plan, including the NHS Digital Roadmap, the following IT-related work has been concluded:

Building on our success of the Summary Care Record deployment, and our SystemOne and EMIS integration we have continued to develop our record sharing technology and ethos with the maturing of our Yorkshire and Humber Care Record (YHCR) and Electronic Palliative Care Coordination Systems (EPaCCS) solution. Four local ICS Trusts are onboarding live data connections into the YHCR with:

- York currently live
- Harrogate onboarding now
- HUTHT onboarding now
- NLaG onboarding in November

We are also providing GP data into the system allowing partner organisations, including local authorities, to receive the latest updates through a Single Point of Truth Record, as we obtain the NHSX MVS 1.0 standard.

The YHCR system will also support improved Population Health Management toolsets.

End of life record sharing has also matured with a single ICS wide EPaCCS solution now in place. End of life preferences are shared in real time between all partners included in a patient's care; this includes:

- Primary Care

- Community Care
- GP OOH
- Single Point of Access
- Secondary Care
- Hospices
- 111
- 999 ambulance services

This system ensures that professionals have access to the very latest patient preferences and are fully empowered to make decisions.

We are now working on maturing our patient held record facility to provide for primary and secondary care records being made available via the NHS App.

We have bolstered our primary care digital offering by providing online and video consultation facilities, along with working directly with PCNs to ensure that digital maturity of staff and patients is understood, we have also deployed smart patient messaging systems to improve patient knowledge sharing and improve 'did not attend' rates.

We continue the work to support the unplanned and emergency care position by ensuring that appropriate logistics and booking enabling tools are in place. We have provided the ability to:

- Allow 111 to book into emergency departments with a timed slot
- Allow 111 to book into urgent treatment centres
- Allow 111 to book into primary care
- Allow the NEL SPA to book into emergency departments with a timed slot
- Allow the NEL SPA to book into primary care.

We are now working on providing the ability to book unheralded emergency department walk-ins into the most appropriate location.

We have worked with care home partners to increase the digital maturity of care homes, and ensured that every care home has access to:

- Secure Wifi
- NHS Mail
- A NHS Laptop
- A 4G enabled tablet for direct remote clinical consultations

We are working with Barclays Digital Eagles to put in place a plan to continue helping care homes with their digital maturity. We are also working with NHSE to produce a Care Homes IT Operating Model to define a baseline level of digital maturity which every care home should aspire to with the support of the wider system.

Workforce enablers of integration

It is self-evident that integration cannot progress, and services cannot be delivered, without staff to do so. NEL has long had challenges in recruiting and retaining health and care professionals; these challenges have been exacerbated over the last year. Whilst BCF monies are not directly funding recruitment activity, workforce capacity concerns are of relevance to BCF in so far as BCF schemes require staff to deliver them.

We have worked with local Ethical Recruitment Agency (ERA) to develop plans for it to hold a number of key staff for deployment across the health/ care system as required. Which area of the system staff are deployed to depends on need. ERA is available to all providers and settings across NEL. Local partners have been asked to drive leads through to the agency with the ultimate goal of increasing workforce capacity within the local system. A marketing campaign was carried out earlier in the year to build awareness of ERA and attract agency staff. The campaign had modest success. Further work to improve the resilience and expansion of the workforce is ongoing, and forms a key part of planning in other areas (for example, via our winter plan). Workforce capacity remains one of the biggest risks to the local health and care system. For that reason, we continue to work with partners – most notably DWP - to explore mechanisms to improve recruitment and retention of staff at all levels (including domiciliary care). This includes monthly recruitment fairs and exploration of packages to incentivise potential workers.

Supporting Discharge (national condition four)

4 What is the approach in your area to improving outcomes for people being discharged from hospital? How is BCF funded activity supporting safe, timely and affective discharge?

A significant amount of work by all ICP partners (including the hospital trust) has gone into improving the local discharge arrangements and ensuring that we are compliant with the initial national hospital discharge guidance, subsequent policy and policy refresh in July 2021.

We aligned to the discharge policy and ensured all discharges were nurse led. Twenty-four hours after discharge each individual is followed up by an appropriate professional to undertake a full review of the person's needs and follow them through their recovery, recuperation and re-ablement journey. A full needs assessment is then undertaken if longer term needs are identified. BCF funding has funded additional capacity within the hospital discharge team (nurse led) and the community discharge team (social work) to ensure discharge to assess processes can be followed.

A daily community hub meeting has been established to ensure there is oversight of each person discharging on pathways 1-3 (circa 55 people/ week), following them through their onward care journey to ensure their needs are met.

In NEL we are working wherever possible to the principle of 'home first', supporting individuals with voluntary sector support via the British Red Cross which has seen its operating hours and range of service offer extended to cover 8am-8pm, 7 days a week, which has been funded from exiting budgets. Plus, the provision of commissioned services via pathway one where necessary. The support at home offer (domiciliary care) has been increased to support timely discharges and to meet increased demand via the just checking service (funded by BCF) and the establishment of a dedicated system pressures supernumerary team (COVID-19 funding). On average 95% of people discharging are going home first.

In addition, BCF funding has been used to contribute to the opening our new enhanced recovery unit within the old Cambridge Park care home. As noted above, this service is currently going through a phased implementation. The service - once it has reached capacity - will be 52 beds, which will include provision of two plus sized rooms. In time, the service will grow to deliver an enhanced community offer including intravenous therapy and a range of complex nursing functions to support a timely discharge from hospital and to prevent a hospital admission. Further to this, we are currently looking to increase our intermediate care/ discharge to assess bed-based offer to support with current

demand. An expression of interest and specification is in development, which will go to all care homes in NEL.

A discharge system improvement group has been established for Northern Lincolnshire to ensure performance is monitored, areas for further improvement identified, and actions delivered (this includes the hospital trust). The discharge executive lead oversees the discharge system across Northern Lincolnshire working with neighbouring authorities as required to ensure blockages/ issues are identified and addressed in a timely manner.

In 2021/22 the areas for development are the full operation of the enhanced recovery unit, a review of intermediate care at home provision (BCF funding is used to contribute towards the intermediate care at home offer), launch of a discharge SOP (standard operating procedure) for all ICP partners to sign up to clearly articulating roles and responsibilities, develop an NEL discharge and onward care performance dashboard and work to further develop the home first pathway with the launch of the enhanced support at home offer.

The BCF has funded many elements of the discharge and onward care process including developments in intermediate care to support a timely discharge from hospital for those without a criteria to reside who require a period of rehabilitation and reablement. The service is already seeing improved outcomes for individuals, with 21% of individuals returning home with no on-going support required.

The BCF also funds additional staff to support with the delivery of 7 day working to facilitate discharges 8am-8pm 7 days a week, meaning that individuals are supported to discharge on the same day wherever possible. The additional staff include increased nursing staff to bolster capacity within the hospital discharge team, additional social workers to support holistic needs assessments within the home environment, additional care staff to support within intermediate care services and support at home provision.

Disabled Facilities Grant (DFG) and wider services

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

DFG progress has been severely challenged in the last year, resulting in increased waiting times; lockdown restricted access to people's homes and a reduced supply chain effected the delivery of materials.

However, despite these challenges, in 2021/2022 there has been an even greater focus on the DFG agenda. Operationally, occupational therapy (OT), technical team and commissioners have met on a monthly basis to ensure the delivery of the DFG agenda and support the launch of the local Housing Assistance and Disabled Adaptations Policy (launched late 2019). This arrangement has been bolstered with the launch of a DFG strategic meeting which now meets monthly with partners from social care, housing, health and finance from across the local authority and CCG. The group monitors spend, has an oversight of the delivery of mandatory and discretionary DFGs and plans the delivery of the wider innovative projects under the Council's discretionary powers to support the people of NEL with their housing needs. Several schemes are currently being reviewed, including increasing the

surveying and OT capacity on site, which includes the recruitment of 5 new employees, focused purely on reducing waiting times, which is now being actioned. The DFG contractor framework has been re-engineered, ensuring there is readily available and appropriate contractors to deliver the major DFG works in a timely way. Telecare, equipment, minor adaptation and major adaptation teams also work much closer together to ensure the individual has the support they need to remain in their own homes for longer and are able to regain or maintain their wellbeing.

As indicated in our last plan, we continue to foster an innovative approach to ensuring the DFG is used to support people to live as independently as possible in their own homes, including:

- Working to support those who have waited for suitable adapted housing on our home choice links register by acquiring stock from social landlords
- Improving the thermal comfort of those who have health conditions which are exacerbated by damp and cold environments
- Specifying our new build supported living facility to meet a range of complex needs
- Developing a trusted assessor approach to minor adaptations, delivering a more direct service and reduced waiting times.

DFG work is undertaken by the Council, CCG and wider partners.

Equality and health inequalities.

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

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

In relation to BCF schemes, NEL's approach to tackling health inequalities remains broadly as set out in our BCF plan 2017/19 (pages 14/15), and reiterated in our 2019/20 submission. All schemes continue to be funded and are intended to contribute to tackling health inequalities. The exception is the Pause Programme, which is no longer funded. Very broadly put, schemes are intended to address inequalities by being accessible to/ reaching out to local people in their communities in a way more likely to tackle disadvantage and increase resilience.

The pandemic has amplified existing health inequalities in the borough and represents the biggest change since creation of the last BCF plan. The 2020 Director of Public Health's annual report, focused on tackling health inequalities, was published during the pandemic. Where possible the report incorporated our developing understanding of the impact of the virus on the factors which result in inequalities, based on the information available. The report highlights, for example, that deprivation may be more likely to result in avoidable admissions for physical and/ or mental health needs, both of which are exacerbated by the pandemic. Further work is needed to improve our level of intelligence, whether from data or from community insight, to understand the evolving challenges and resources for health and wellbeing in local communities.

Latest understanding on the changes arising from the pandemic can be found in the impact assessment <https://democracy.nelincs.gov.uk/wp-content/uploads/2021/05/9.-Covid-19-Impact-Assessment.pdf> (health and wellbeing narrative begins on page 10, and adult social care on page 20).

The public health annual report can be found here:

<https://www.nelincs.gov.uk/assets/uploads/2021/03/Director-of-Public-Health-Annual-Report-2020.pdf> It is accompanied by recommendations (for example, see page 8) and gives an update on recommendations from the previous year's report (see page 55). Whilst action to address the recommendations is on-going, progress has been made in some areas, notably in respect of exploring a methodology for measuring equity of access to services and in building social connectivity (by increasing digital skills, sustaining and building on well-used community assets (physical and virtual), and by reviewing the commissioning of the voluntary and community sector including the use of social prescribing).

CCG and public health colleagues continue to work with the ICS in a range of ways to tackle inequalities in the broadest sense; some examples include:

- People with severe mental illness are often living in the most deprived areas, and have limited access to technology which enables them to access services. This has contributed to previously acknowledged poor health issues. We are re-focussing and re-asserting annual physical health checks for this population
- Similarly, people with learning disabilities have been adversely affected by both corona virus and the social restrictions imposed in the management of it. Annual Health Checks are vital in improving the quality of people's lives, and an active campaign to ensure these are done effectively across NEL is seeing significantly improved numbers of people having their check. The support of the Learning Disability Wellbeing Team is key to enabling access to physical health care. We are about to start a bowel cancer screening programme, reasonably adjusted to people with learning disability needs
- Access to mental health support has been challenging to many. Primary Care and VCSE sectors have highlighted a disproportionate number of people who are, or were, Looked After Children seeking assistance or support following being declined service from the statutory sector. We are working with Primary Care and VCSE to enable a more Trauma Informed approach to supporting people's lives
- More children, young people and adults with eating disorders have sought more help and at a more complex level than previously. The CCG has secured a short term provision to support people in the community whilst a longer term solution is sought
- Dementia – people have not been forwarded to GPs and diagnosis rates have fallen. Residential care has seen significant loss of people with dementia from the sector as many have sadly died due to vulnerability to the virus. Information and support campaigns are being activated.

A Union Equality and Diversity Core Group has been established to ensure that the Council and CCG (the Union):

- meets the duties under the Equality Act 2010 in our direct service delivery and commissioned activities
- works with other partners to contribute to reduce health inequalities across NEL
- promotes equality, diversity and inclusion across our workforce and communities

The Core Group's objectives include creation of a targeted E&D (equality and diversity) plan, aligned where relevant, with the recommendations in the public health annual report and drawing on the findings of the impact assessment. Work to ensure that equality impact assessments are mandated as part of the commissioning cycle has concluded, although further work is needed to promote routine E&D considerations as part of contract monitoring.