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 but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to 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 15-20 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.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board(s)

North East Lincolnshire

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

In addition to sharing the draft plan with key individuals across health, care and housing (including DFG), the plan has also been shared with:

- Health Care Partnership (HCP) leadership group, comprising
  - *Humber and North Yorkshire Integrated Care Board, North East Lincolnshire Place*
  - *Care Plus Group (CPG)*
  - *Core Care Links (GP out of hours)*
  - *Focus Independent Adult Social Work*
  - *Navigo*
  - *Northern Lincolnshire and Goole (NLaG) NHS Foundation Trust*
  - *North East Lincolnshire Council*
  - *Primary Care Networks (PCNs)*
  - *St Andrew's Hospice*
  - *St Hugh's Hospital*
  - *Sector Support North East Lincolnshire Partnership (representing the VCSE (voluntary, community and social enterprise) sector)*
- Centre4 (hosts connectNEL/ Simply Connect)
- Healthwatch.

How have you gone about involving these stakeholders?

The overarching BCF plan has been shared in draft form for comment. There has been more detailed involvement in some aspects of the plan, for example input from CPG into the capacity and demand plan.

The BCF plan reflects a) the Council Plan, b) the Humber and North Yorkshire Integrated Care Strategy, both of which build on the Adult Strategy 2019 - 2022, noted in previous plans.

The draft Council plan was consulted on via all scrutiny panels, shared with the voluntary and community sector via the VCS Forum, and with the Place Board (comprising representatives from health, fire, police, education, business etc) before being adopted by full Council.

The Integrated Care Strategy was devised by a strategy design group (comprising Council and ICB representatives) and based on the lived experiences of citizens/ communities. Engagement took place with a variety of stakeholders, including those which appear above.

Due to the tight timeline within which a BCF plan must be created, genuine involvement in the BCF plan itself is limited. However, in having input into the Council plan and Integrated Care Strategy, partners have to a degree been involved in development of the BCF plan.

Governance

Our governance arrangements are as set out in our previous plan (page 3).

SIGN OFF OF PLAN: the draft plan was supported in principle by the Joint Committee on 31st May 2023. At that time, it was awaiting regional comments. The final plan has been submitted using delegated authority and will be signed off by the Health and Wellbeing Board on 10th July 2023.

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

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Key changes

The Integrated Care Strategy (finalised since creation of our last BCF plan) creates the framework for plans at Place. It sets out an ambition for 'everyone in our population to live longer, healthier lives', by taking a life course approach intended to ensure that all 'start well, live well, age well and die well'. Similarly, the newly refreshed Council plan 2023 – 2026 sets out an intention for North East Lincolnshire (NEL) to be a place "where citizens of all ages live active, healthy and independent lives". The Council plan reiterates the vision for adults described in the Adult Strategy 2019 - 2022 ("all adults in North East Lincolnshire will have healthy and independent lives with easy access to joined up advice and support, helping them to help themselves") and uses the new 'start well, live well, age well, die well' structure to frame priorities. 'Care well' has been added, to ensure carers' needs are prioritised.

The local intention remains to "maximise the benefit to North East Lincolnshire through the Health and Care Partnership arrangements, building on the legacy of the NELC/ CCG Union, to join up health and care provision in a way that provides better support and social care and makes best use of resources". There is a new local delivery plan for adults, as part of the Integrated Care Strategy. The plan is focused on the following areas:

1. Starting well: supporting young disabled people to transition to adulthood with the right support as close to home, families and communities as possible
2. Living well: supporting working age adults to live as independently as possible
3. Aging well: supporting older people to live as independently as possible, for as long as possible in their own homes
4. Caring well: supporting carers who are looking after family members, friends and neighbours
5. Dying well: supporting those reaching the end of life to do so in a dignified way, wherever possible with support at home.

The Joint Committee has oversight of delivery. As noted in our previous plan, this committee comprises representatives of the Council, Health and Care Partnership (HCP) and ICB. The Council plan, with updates, is here: **https://www.nelincs.gov.uk/your-council/council-plan-vision-and-aims/**

Priorities

Joint priorities are detailed ~~using the life course structure~~, in the section below. These are largely reflective of previous priorities, updated and restructured to reflect new arrangements. Changes are flagged where relevant.

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:

a) Joint priorities for 2022-23
b) Approaches to joint/collaborative commissioning
c) How BCF funded services are supporting your approach to 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.

Our approach to embedding integrated, person-centred health, social care and housing services remains as set out in our previous plans. Relevant parts of the Council Plan and Integrated Care Strategy represent a continuation of the approach set out in the Adult Strategy, namely to promote population health and independence at place.

Joint priorities for 2023 – 25 (relating specifically to adults)

- Implement the Findings of the Rehabilitation and Reablement Review - work towards providing more efficient and effective reablement, reducing reliance on long term care packages and formal services. The key workstreams will bolster strengths-based approaches, improve our use of technology enabled care (TEC), improve identification of and support for carers and ensure we offer reablement help to all those who would benefit. This builds on work set out in our previous plan.
- Get better value from care - continue to ensure that people get care and support that meets their needs in the most effective and efficient way. This is a rebadging of work referenced in our previous plan (see page 15), focused on developing/ embedding asset-based and outcome focused approaches to care with the help of 'Care Cubed' (a benchmark tool offering comparison of local and national care costs). It is linked with the next bullet point.
- Develop a Strengths Based Practice and Asset Based Approach - develop a strengths-based practice framework to support social workers across partner organisations to develop the way they undertake needs assessments, care planning and reviews. Develop specifications and contractual arrangements for the delivery of social work to make it clear to staff and residents what is expected and how effectiveness is measured. Focused initially on social workers, the practice framework will also be rolled out to other relevant professionals engaged in assessment, care planning and review.
- Develop the Supported Living Plus Service – following completion of a business case and resulting plans, develop services for disabled adults to ensure that we have a housing and support offer within the Borough meaning more people can get the support they need closer to families and the communities they grew up in.
- Housing related support - develop our range of support for older adults with the aim of delivering two further 90 bed extra care housing schemes. This will build on the market testing exercise referenced in our previous plan (page 5), intended to identify suitable partners and the best model for NEL. We will also explore the introduction of Shared Lives to provide new opportunities for adults to live in family homes as an alternative to other forms of care and support (exploration of Shared Lives is a new priority, which we hope to launch in April 24). Supported Living Services will be further developed to ensure they can respond effectively to residents.

- Build the range of community-based preventative, care and social support services - last year we reviewed day opportunities and transport services on offer for people in NEL. In 2023/ 2024 we will bring forward proposals to develop this offer, and the resources offered by the VCSE sector. This work will require the further development of strategic and delivery relationships with partners in the VCSE sector. It will aim to develop the sector's role in preventative, information advice and guidance and community-based support.
- Develop our approach to the use of technology - we will develop the way we work to make better use of technology, including in the course of providing advice and guidance (including via LiveWell as referenced in our previous plan, page 4), digitally supported assessment, the use of assistive technology to support the delivery of care and support and to support people to manage their own lives as independently as possible.
- Develop the workforce - We have a new adult social care workforce development plan in NEL that will support action to promote the value of social care, help employers with recruitment and retention, build the training and development offer for social care workers and link to the NEL Wellbeing Academy. Workforce activity is undertaken cooperatively by partners across health and care.

Further information on some of these priorities is given in the remainder of this plan.

Approaches to joint/ collaborative commissioning

As before, all BCF initiatives are commissioned and/ or delivered via the s75 agreement. This includes the work arising from all the priorities listed above. Governance for joint/ collaborative commissioning is provided via the Joint Committee. We offer the following illustrative examples of joint/ collaborative commissioning using BCF funds:

- Single Point of Access (SPA)

As noted in our previous plan (see page 4), the SPA – our integrated 'front door' - is commissioned by the ICB at place, on behalf of itself and the Council. The SPA continues to offer health, mental health, social care and therapy access for professionals and the public in NEL. Over the year 2022 to 2023, average calls into the SPA for adult social care were 4149 per month. The highest proportion of these – 16% - were from individuals or their friends/family and 12% were from other health and social care professionals including primary care and community nursing. The SPA processed approximately 175 occupational and physiotherapy referrals per month during the same period. SPA's newest option, which links to connectNEL (the wellbeing hub referenced in our previous BCF plan, and part of our preventative offer), averages around 130 calls per month. Call handlers continue to utilise an asset-based philosophy, supporting individuals to identify their strengths, offering them tailored advice to capitalise on their abilities. The Govmetrics contemporaneous feedback system reports high levels of positive experience.

- Assisted Living Centre (ALC)

Wider work across health and care supporting the independence agenda includes the work with the ALC to ensure the service is right sized and delivering the equipment needed to support innovative methods of care delivery, for e.g. single handed care. The specification and revised KPIs (key performance indicators) referenced in our previous plan (page 7) have been developed and agreed. This will ensure the service continues to develop to best support local need.

How BCF services support integration

The vast majority of the services described in previous plans continue to be funded, in ways intended to provide continuity with previously espoused objectives (and listed under 'priorities' above). A further example is given below of how NEL's approach is intended to support integration:

- Care home provision and support to care homes

In the coming months, a Housing with Care Strategy (further detail on page 22) will align with other housing strategies at Place. This will include development of shared care home commissioning intentions in NEL. Following an initial meeting with providers, we have devised a focused approach to further discussion with them about care home services, starting May 2023.

For some individuals, a residential setting is the best place for them to be cared for. Despite significant ongoing pandemic-related pressure (the risk of outbreaks and loss of staff), providers have worked with us to complete a fair cost of care exercise using the national toolkit. Our market sustainability plan is likely to be a significant driver in the further development of care in residential settings, to ensure the local offer is the right one for local people. We will need to work with providers to try and reduce the overprovision in care homes, and consider whether premises are fit for modern care challenges. These developments of our existing shared approach apply equally to residents funded via continuing healthcare, s117 and adult social care.

Improving outcomes

To summarise, prioritising on these areas will:

- Better support individuals to maintain or regain independence
- Provide them with help tailored to their individual strengths
- Increase the range of housing with care and wider community resources available
- Develop the technology and staffing required to deliver the above.

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 support 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.

Enabling people to stay well, safe and independent

Our vision – that adults will have healthy and independent lives – has already been set out. This promoting independence model 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 is intended to be reablement based, challenging people to do more for themselves, and consistently reassessing their ability to maintain, gain or regain skills wherever possible. Success is defined 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). Our approach to 'safe, well, independent' remains as set out in pages 14/15 of our previous plan.

Working with primary care (examples)
The offer of extended access to general practice Monday to Friday 8am to 8pm and Saturday 9am-5pm continues and is now incorporated as one of the national specifications for PCNs (primary care networks). It continues to be delivered on a collaborative basis by local practices working together in their PCN groupings. The local offer is a mix of face to face and digital support, using a multi-disciplinary approach (GPs, nurses, heath care assistants, clinical pharmacists, physiotherapist, advanced curse practitioners and paramedics), and includes a mix of planned and urgent appointments covering the services set out in our previous plan (pages 15/16). Extending access and variety of ways to engage with primary care is intended to help people stay well and safe.

We also have the Primary Care Enhanced Frailty service that focuses on proactive care for identified patients. It includes those who are frail, at end of life, supports those who have had an admission, and supports individuals in their own home. The service uses an MDT approach and involves other community teams/services where relevant to provide holistic support to individuals.

In response to the Fuller Stocktake, we are also developing five Integrated Neighbourhood Teams (INTs) which in NEL is focused around the population of the PCNs. The INTs will have professionals spanning many modalities, including District Nursing, mental health, wellbeing and social prescribing links, as well as adult social care and other key partners. We held an initial workshop with the PCNs and community nursing teams to discuss barriers/ how to improve integration to provide that more joined up care. In the current year, organisational development workshops are planned with each INT to support development of their visions and values, and how they will work together as one team, across organisational boundaries. Population health management support is being accessed to drive forward the priorities for the INT. This means that each INT will be given the specific data for the population they are supporting, allowing them to target the issues the data highlights as the most significant.

All PCNs already have care coordinators who, for example, help to manage care for patients on the Network's frailty register. Building on this coordinator model, each PCN will have an integrated neighbourhood team coordinator, who will ensure that highest need individuals are proactively targeted. Drawing on support from social workers, mental health workers, the Wellbeing Team etc will ensure provision of holistic care from the right range of experts, to support individuals to remain safely at home. These plans are in development and will progress during the lifetime of this plan.

Working with reablement and intermediate care (examples)
Reviewing our reablement provision and creating additional reablement capacity (step up/step down) remains a focus of activity for this year and into 2024/2025, as well as improving length of stay and outcomes for individuals. The IMPOWER review of our social care and reablement provision will inform our programme of work. A task and finish group has been established to steer the work and facilitate the improvement required.

Work is ongoing to increase the number of intermediate care beds at Cambridge Park (CP) community inpatient unit, as the main bed based intermediate care provision (referenced in our previous plan, page 7). We continue to deliver our block book enhanced recovery beds (ERB) and the spot purchase framework to ensure that all those with reablement, rehabilitation and recovery potential can access support. Through the door, social work, nursing and therapy provision ensures MDT support to individuals. Work in the coming year will move from a focus of launching these beds (CP and ERBs), to embedding strengths-based practice, monitoring outcomes and supporting individuals to return home and stay at home, with reduced need for long term services.

Alongside the work on bed-based provision, we will focus our attention on intermediate care at home, to understand the model, capacity and the efficiency and effectiveness of provision. Demand forecasting and establishing an understanding of future requirements will inform an intermediate care improvement plan.

A reablement performance dashboard will be developed to ensure we have oversight of the delivery, quality and achievements for bed based and home based reablement.

The ICB is also focusing its attention on intermediate care, so our work at Place will feed into and support the wider ICB agenda.

Working with services in the community (examples)
Care at home
Our 'teams not times' model has been useful in allowing flexibility, during very pressured times. However, we recognise concerns that its flexibility does not resolve all the issues the model was designed to address especially with regards to improving satisfaction and the number of visitors/visits made. We will therefore review the model and further refine it, to ensure care workers are enabled to deliver personalised and asset-focused care and that those in receipt of care understand the benefits of flexible provision.

A pilot of an enhanced skill set for support at home cares was carried out with a single provider. Data gleaned from this pilot is being reviewed. This data and feedback from an end of pilot questionnaire for care workers will be included in the review of the model, to shape future commissioning specifications. The care at home specification applies to continuing healthcare, s117 and social care funded users. All users, regardless of funding, are able to benefit from the same access and outcomes – intended to help them stay independent at home. This will link to the overarching housing with care strategy.

A lead occupational therapist has been working hard across the latter part of 2022/ 23 to drive forward the single-handed care project, designed to improve the efficiency and effectiveness of support at home services and improve outcomes for individuals. The project aims to embed a philosophy of reduced care handling; improving techniques for both the individual and care workers, and aiding people to be supported by their informal carers and/ or in their home for longer. Phase one of the project, as set out in our previous plan (page 6/7), is well underway. It has included working with support at home providers to identify individuals who may benefit from reassessment with single-handed care in mind. So far 83 referrals have been received for the project. The work is being developed in liaison with support at home providers and referrals have come from providers in the first phases of the project. Work is completed on 16 of the referrals. A further 31 are the subject of further assessment, five are booked for initial assessment and 31 are awaiting allocation.

This first phase has also included general awareness raising, support and training on single handed care for professionals, including social workers, therapists, and allied health professionals. We have secured items of equipment in our ALC and are in the process of developing an equipment satellite site, so the deployment of single-handed care equipment is efficient and effective. The remaining phases in the single-handed care project are detailed in our previous plan, and will continue during the lifetime of this plan.

Core care at home provision is also supplemented by system pressure teams. The teams work to support those discharging into the community from hospital or step-down bed-based care, where their lead support at home provider cannot pick up the package of care straight away. These dedicated teams fill the gap between the discharge date and the date the lead provider can start (up to 14 days). Since the launch of the system pressure teams last autumn, the teams have delivered nearly 4,000 care calls, saving just over 1,400 lost bed days. This additional resource has been so successful, that use of system pressure teams will continue into 2023/ 24.

Social prescribing

Joint work with local VCSE organisations to deliver a social prescribing programme – Thrive NEL – continues to be successful (see last year's plan, page 16). The service is focused on offering a personalised and asset-focused approach to the areas of greatest significance to individuals. The service has grown during 2022-23 with an average of 70 referrals coming into the programme each month. To ensure that the service remains responsive, a debt advice worker was recruited into the team to further enhance the holistic support for programme participants impacted by financial difficulties arising from the cost-of-living crisis.

Whilst retaining flexibility to respond to changing circumstances, the offer via Thrive has largely become 'business as usual' in NEL and will continue for the lifetime of the BCF plan. We will soon enter into negotiations for an extension of the Thrive contract which will involve a review of outcomes and expected targets, to ensure that results for participants are optimised. The planned evaluation of Thrive's impact, in terms of the difference the interventions have made to participants, as well as the reduction in the use of health and care services, is still outstanding. Our aim is to utilise university research teams to facilitate this, which will offer an independent perspective.

Working with adult social care services

As already noted above, one of our priorities is the development of a strengths-based practice framework to support social workers across partner organisations to develop the way they undertake needs assessments, care planning and reviews. The first draft of the framework is complete, having been co-produced with social workers across organisations. We are now moving into phase two of the framework's development - wider stakeholder engagement on the framework - before finalising it. A programme of work will be undertaken across partner organisations to embed the framework and ensure that its independence-promoting ambitions are realised. There is more information on page 20 below.

Working with carers

Supporting carers to continue to support those they care for is often a very effective way of enabling individuals to remain at home for longer. Further information on our work with carers can be found on page 21.

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.

We have monitored flow, referrals, volume, length of stay/ service delivery, outcomes and sequel to services for our intermediate care provision for community and discharge referrals. Demand for bed-based and home-based intermediate care has been reasonably consistent throughout the year and roughly as predicted. We have managed to meet the presenting demand from the community. Many people were supported in the provision they required, with minimal waiting lists and waiting times to access.

Our approach to estimating capacity and demand has been based on the capacity and demand we have seen from the community in 2022/23.

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.

Unplanned admissions to hospital

The local approach to unplanned admissions is set out in the planning template at tab 7. Some of the activity described in the narrative in the planning template is supported using BCF funding (for example support to care homes – see below) and/ or has been referenced elsewhere in this narrative template (for example Thrive, social prescribing). As the narrative in the planning template

indicates, some of the activity intended to address the planned admission metric is a continuation of existing efforts and some of it is new.

The Support to care Homes Programme has been running for a number of years. Its key workstreams are:

1) Falls prevention
2) Improving nutrition and hydration
3) Pharmacy support
4) Oral hygiene
5) Care home digitisation
6) Red Bag Scheme.

The first three are specifically designed to try and reduce causative factors which increase the risk of admission from, slips trips and falls, chest infections and urine infections. This is done by piloting and developing new ways of working to improve the care offered. Work this year will focus on developing our local Homely Remedies policy, reducing falls risks. A pilot of a digital solutions to engaging with community nursing and dieticians is moving into a second phase. Initially only piloted in one care home this has now been expanded to three care homes all supported by a single PCN and community nursing team. It will provide routine health and wellbeing information to the community nursing team and GP's and will be linked to the care home MDT.

Emergency hospital admissions following a fall

The falls project, as part of the Support to Care Homes programme, is presently supporting a pilot of the iStumble App in three care homes, however it is anticipated that this will expand to nine homes within the year. Work is also continuing to expand the pilot of the DOCOBO Doc@Home App with Meridan PCN and the community nursing team which should allow for more responsive monitoring of a resident's overall health and wellbeing. This will focus on the trial of a wellbeing/ frailty tool to help identify those residents who may be liable to noticeable deterioration and speed up the passing of information to the MDT. As the evidence builds, we will work with different homes on other ideas to pilot this connected technology further. The intention is that vulnerability to falls can be addressed promptly, to avoid hospitalisation. Again, this work will benefit all residents, regardless of how their care is funded.

Facilitating a community urgent care response to falls allows for greater flexibility in supporting fallers to remain at home with appropriate support thus reducing admissions. The Community Urgent Care Team assist in lifting fallers, monitoring the patient's condition and reviewing them for a period following a fall. As the service is embedded in the community team, referrals to other support services that may reduce the risk of future falls is embedded in the service delivery model.

Over 65s admission to residential care

NEL has an aging population with an increasing complexity of need. Our approach to reablement/ home first and supporting people to remain at home helps to reduce the number of people over the age of 65 whose long-term support needs are met by admission to residential/ nursing care. Further work will be picked up to identify the skills and resources needed to provide support for those with more complex needs and keep them in the community for longer. This work is linked to the development of a Housing with Care Strategy to try and ensure that the range of options, and skills needed to support our population, are developed to address specific local needs.

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:

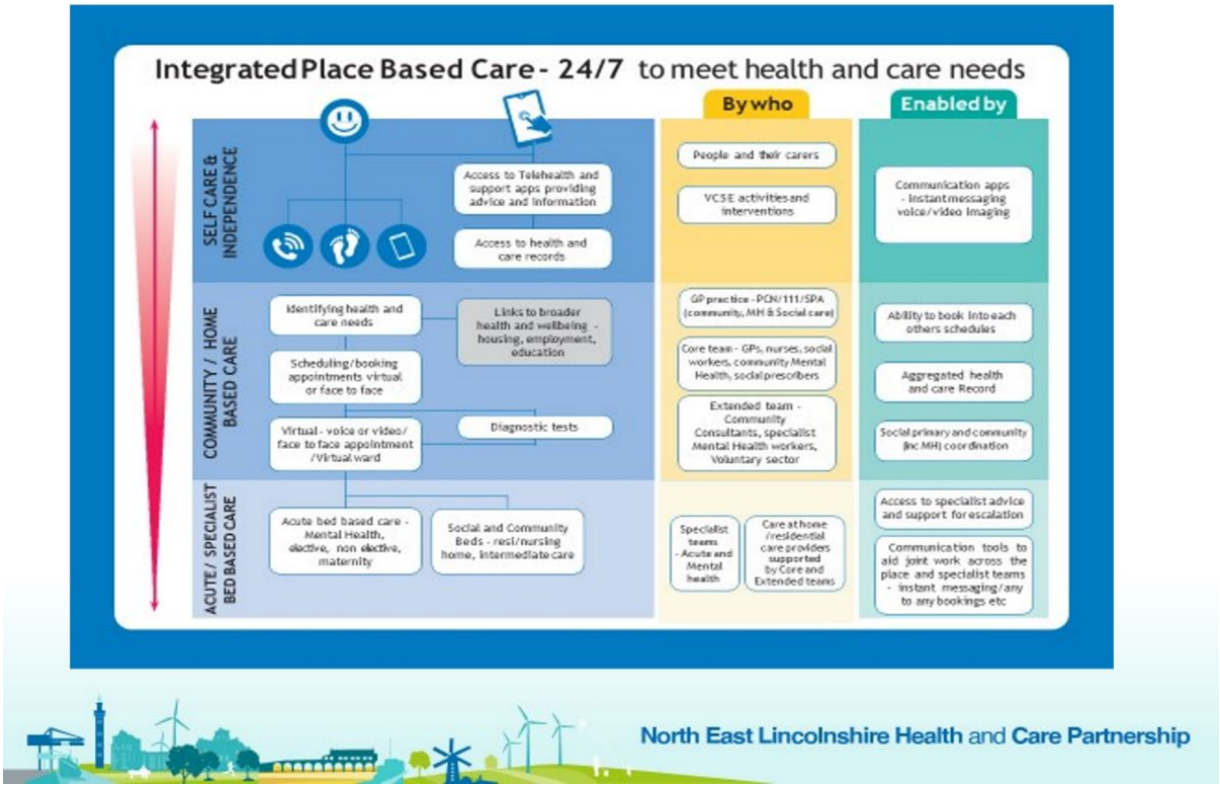
- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- 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.

Our approach to 'right care, right place, right time'

The diagram below sets out the HCP's operational model (slightly revised since our last BCF plan, on page 18), designed to deliver the right care in the right place at the right time. As before, the model is intended to direct people away from acute care and towards community and home care options wherever appropriate.



Home first and investing in social care

As we operate an integrated health and care system, the work around hospital discharge has very much focused on the patient, process and pathways rather than who is financially responsible for supporting the individual. Daily reporting on the discharge returns showed that nobody received bed-based care that should have gone home first.

We have bolstered our VCSE and domiciliary care capacity to ensure there is availability in community services to accept pathway 0 and 1 discharges in a timely manner. The VSCE offer comprises home from hospital support, telecare for up to 6 weeks, and carers' support. The home from hospital service has been fundamental to supporting people to go home first, be it by providing transport, access to wellbeing support or access to food and a habitable home on discharge. Other VSCE support has been pivotal as a wraparound offer to make home first an option. For example, the dedicated carers' support worker presence at the hospital, identifying and working to support carers, has meant carers are more able and willing to take on or resume caring responsibilities post discharge. Additional investment in telecare for those discharging on pathway 0 and 1 has provided reassurance and peace of mind that the person has support at the press of a button. Both services have supported individuals to go home first, that would otherwise have needed pathway 2/3.

In addition, we have invested in 2, soon to be 3, proactive discharge coordinators. Their focus is on working with patients at the point of admission to look at needs, wishes and options post-acute care, working with the patient and their families/ representatives. This means there are no/ reduced discharge delays at the point the individual no longer has criteria to reside. Often the roles work very closely with VSCE organisations to refer patients into their services rather than formal commissioned support as the discharge is planned and all parties are engaged and accepting of help.

Additional bed-based block and spot enhanced recovery capacity and additional intermediate care beds (rehab, reablement, recovery and recouperation on pathway 2) was launched in 2022/23 and will continue into 2023/24. This has ensured that where individuals need a short period of rehab, reablement or further assessment in a bed-based setting, it is available. Capacity to support pathway 3 is already in place and we have vacancies across our residential and nursing care market to meet demand.

We have moved the full longer term needs assessment of individuals into the community when they have reached their optimum level of recovery. To support this, we have funded additional MDT community resource (social work and therapy). Although we operate a discharge to access model, the hospital discharge team still need to prescribe immediate short term support for those requiring pathway 1, 2 and 3. To ensure these conversations are only about the patient's needs and to support same day discharge, we have launched an integrated discharge fund, which funds the first 7 days of pathway 1-3 support including that of self-funders so decisions on finance can also be undertaken in the community although with assessing longer term needs.

Note: discharge funding is being spent in line with grant conditions. Some of this year's discharge funded schemes are a continuation of last year's discharge funded schemes.

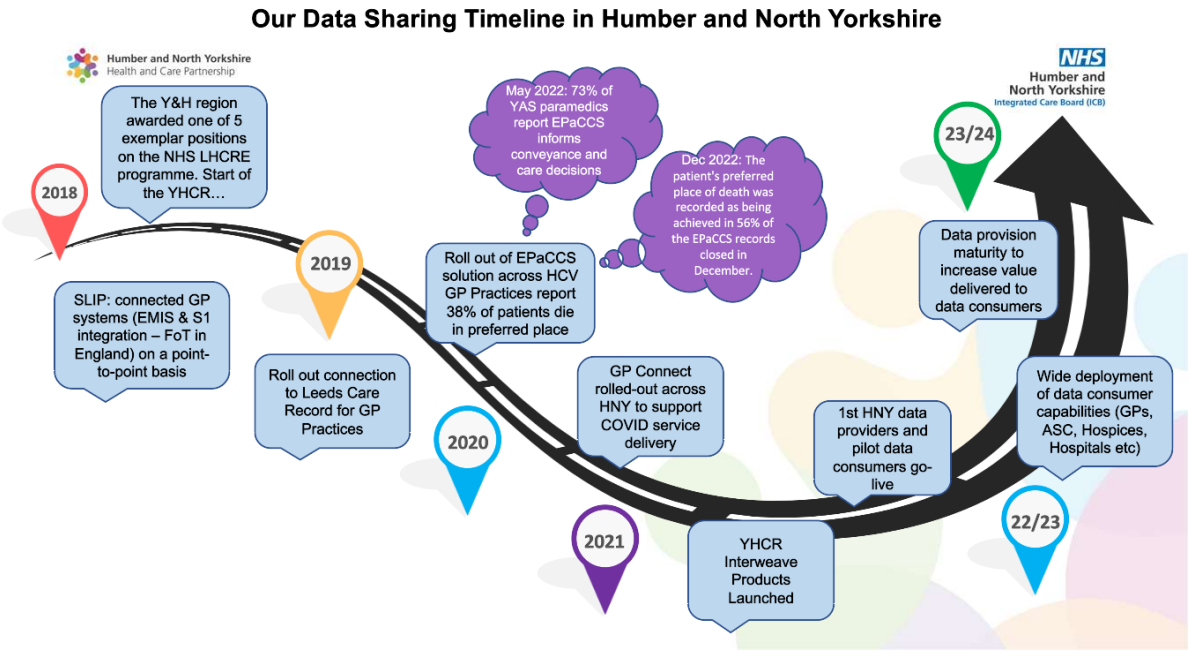
Sustaining improvements and wider system flow

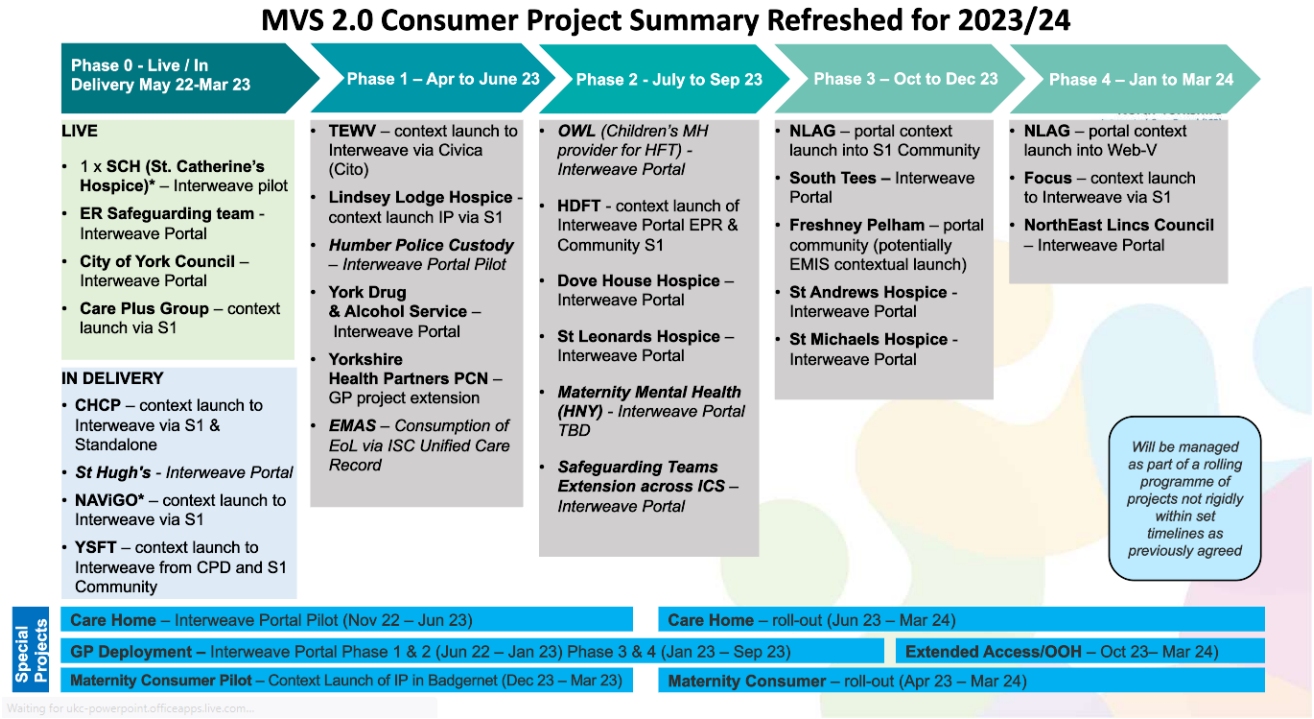
Workforce

One of the key enablers for care – at the right place and time – is a sufficient and skilled workforce. Workforce capacity remains one of the biggest risks to the local health and care system. This includes hospital-based staff to facilitate discharge, and community-based staff to 'receive' and support those being discharged. Work continues (see previous plan page 13) via our local workforce development group which drives our partnership work on recruitment and retention. We have piloted two recruitment schemes to consider the impact of different approaches in supporting providers directly which have had good feedback from providers and candidates. Our workforce plan for adult social care in NEL, linked with wider health and care workforce programmes, is focused on promotion of careers and opportunities in care, recruitment, retention, continuing professional development and wellbeing. We continue to use events e.g. job fairs and other methods to promote roles in heath and care, working with partner organisations, including NLaG, Navigo (mental health services) and CPG (community health and care services, and Employability Service), and DWP. This activity – partly funded via the discharge fund - will continue during the lifetime of the BCF plan.

Digital

An essential component of ensuring delivery of the right care, at the right place and time, is the ability to share information between partners in a way that enables individuals to flow around the wider system (from primary, intermediate, community and other care settings). Building on the success noted in our previous plan (page 11), 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. In addition to those listed in our previous plan, all ICB NHS hospital trusts are now live with data connections into the YHCR as well as an additional local authority (now five in total), safeguarding teams, community provider and a private hospital. Our Record sharing journey is illustrated below.





As we continue our shared record journey, we have planned the following 4 phase deployment over the next year:

Further examples of digital work to support delivery of the right care in the right place/ time include (building on previous narrative at pages 11-13):

- The YHCR system will support improved Population Health Management toolsets, and we are working towards connectivity with the national Federated Data Platform (FDP). The PCN IIF Capacity and Access plans are being developed and include the utilisation of digital support, including utilisation of online consultations in GP practices. Practices are provided with communication tools to remind patients of the different ways to access their practice, including digital options. This helps patients to continue accessing support via their GP, and avoid the need to call on urgent and emergency services.
- End of life record sharing has continued to mature, allowing all partners involved in a patient's care to access information on end-of-life preferences either directly through native systems or through the YHCR integrated care record. This system ensures that professionals have access to the very latest information to enable the right care to be delivered at the right time and place, and in particular to die at home (if that is the patient's wish).
- We are working with the Community Collaborative across the ICS to deploy a bed capacity and demand tracker which will empower improved decision making through better system intelligence, allowing for beds to be freed in hospitals by moving patients to the community. This system is being delivered using the national FDP ensuring that we are 'future proofed'.
- The Care Home Digital Maturity service continues to assess the digital maturity of care homes and support them to improve connectivity into the wider care community. The service signposts to support services and assists in the collation of potential funding streams, to enhance the use of Digital Social Care Records across the HCP. This also includes

opportunity to enhance the remote digital care offerings to residents and to those who are receiving care at home.

- We continue to work with our health and care colleagues to provide improved diagnostic capabilities in the community, and avoid acute settings where possible. By creating either mobile or static hub based diagnostic facilities we create new capacity in the system, allowing quicker patient throughput, faster diagnosis and better outcomes.
- Across the HCP, we have a dedicated self-care apps store in place, which allows our local population access to a wealth of health and wellbeing apps, that have been rated as clinically safe and accurate by the team at ORCHA (Organisation for the Review of Care and Health Apps. We are also running a Waiting Well campaign to target the Elective Care backlog, directing those who are waiting for appointments to targeted apps, to support with their wellbeing while they wait.
- To further enhance patient care in urgent and emergency care settings – and beyond - we continue to develop a booking and referral system to allow patients to be booked directly from one service into another service, reducing delay and administrative overheads and improving patient experience. This solution will be integrated into the YHCR and will be fully compliant with the national Booking and Referral (BaRS) standard. We have supported creation of the HCP specific Digital Board, to ensure that Place has a strong voice in ICB digital discussions as well as linking into ICB strategic requirements. This has led to the recruitment of a dedicated HCP Digital Lead.
- To simplify the process of sharing patient level information we have been working with the ICB to create an outline information sharing agreement which will allow social care providers and health services to use a simple format. If successful it is hoped this will be adopted across the ICB.

Working with the VCSE Sector

The Council and ICB at Place continue to fund Sector Support NEL (SSNEL) (https://www.sectorsupportnel.org.uk/) which works in partnership with an Alliance of leading VCSE organisations. The role of SSNEL in supporting not for profit organisations to build capacity was set out in our previous plan (page 7). SSNEL represents the sector in the HCP and is VCSE lead at Place. Grant administration during and since Covid has been used to enable VCSE organisations to alleviate hardship, address isolation and maintain organisations and their volunteers during a challenging period. For example, the Later Life Partnership (comprising Friendship at Home, AgeUK and Carelink) has been funded to support older people to access benefits such as warm home discounts, so helping them to stay independent at home for longer. Project targets were exceeded.

SSNEL has also supported the distribution of discharge fund monies to local VCSE organisations working to support discharge and to maintain independence at home. VCSE partners are often able to provide the lower level and longer-term support which improves outcomes. They are a crucial part of the local offer, and frequently key to ensuring that individuals are supported in the right place for them, and in a timelier way. Recognising this crucial role is one of the reasons why Locality (https://locality.org.uk/the-power-of-community) has been commissioned by the Council. Locality is tasked with reviewing VCSE infrastructure support arrangements, and analysing how best to enhance the role of the sector in local service provision (including but not limited to, adult social care and health). The review will consider current provision and operating environment for the VCSE in NEL and make recommendations on opportunities for the future. It will report in the near future.

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.

The monitoring of our intermediate care services has been part of our discharge and onward care work in 2022/23. We have monitored flow, referrals, volume, length of stay/ service delivery, outcomes and sequel to services. Demand for bed based intermediate care has been reasonably consistent throughout the year and roughly as predicted to support hospital discharge. We have managed to meet the presenting demand. Many people were supported in the provision they required, with minimal waiting lists and waiting times to access. Individuals requiring bed-based rehab/ reablement were all supported within our main bed-based facility at Cambridge Park or within our enhanced recovery beds in care homes. Those requiring rehab/ reablement in their own homes, received this at home. Nobody went onto pathway 2 from hospital, due to intermediate care at home not being available. In a small number of cases, our domiciliary care provision supported the lead in time, before intermediate care at home could commence.

Our approach to estimating capacity and demand has been based on the capacity and demand we have seen in 2022/23 allowing for any additional services commissioned as part of the discharge monies and trends in demand. Any gaps already identified in provision have fed into the prioritisation of 2023/24 and 2024/25 discharge money discussions and BCF commitments. For example, we will continue to:

- bolster our VCSE support to maintain the increased prevention and wellbeing offer and home from hospital services, which supports with low level reablement, promotion of independence and improved wellbeing.
- Maintain our increased intermediate bed based and enhanced recovery beds offer, as demand has shown the capacity is required into 2023/24.

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

All the discharge initiatives/ schemes supported by the discharge funding and BCF are driven from the premise of home first and discharge to access, which has significantly supported our ability to discharge people to their usual place of residence. In a small number of cases, we have also achieved improved outcomes for individuals, who came into hospital from a care home short stay placement, who have returned home, rather than back to bed based care. In particular, right sizing the community offer on pathway 1 and 2, the launch of the proactive discharge coordinators and supporting positive risk taking, have helped us achieve on this metric.

National Condition 3 (cont)

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

The bi-weekly discharge system improvement group continues to monitor our discharge system. This includes monitoring items escalated from the various operational groups, and agreeing actions to address the areas for concern/ improvement/ gaps. Our 2022/23 discharge improvement plan was based on a self-assessment of our compliance to the discharge guidance, HICM and the 100-day discharge challenge, the findings from our multi agency discharge event (MADE) and any other general best practice we were made aware of. Having recently appointed a new single coordinator (Programme Director Home First Transformation) we are commencing a full review and update of our discharge system improvement plan.

We have made progress across all nine change management areas. A summary of the improvements include:

- dedicated work to ensure all patients on admission have an EDD and work to arrange discharge starts well before the patient no longer has a criteria to reside (change 1).
- As we are an integrated health and care system, we already operate effective multi-disciplinary working; however a significant amount of work has occurred in bringing MDTs together to wrap around the patient to ensure a coordinate approach to assessment and the delivery of support (Change 3).
- Our additional capacity in community provision (support at home and VCSE) has really improved our ability to ensure individuals who can, go home first. The number of patients discharging with VCSE support has more than doubled since this time last year (Change 4).
- Although we had trusted assessment to support hospital discharge, utilising the discharge facilitation form, this has been reworked to better meet the information needs across all pathways. It is now used across all transitional pathways (step up and down) and has been renamed the pathway facilitation form (Change 6).

- As discussed above, the discharge coordinator roles which launched in 2022/23 have significantly supported our ability to plan for discharge prior to the patient no longer having criteria to reside. This has meant that there is much more time to consider patient and carer needs and wishes and include them fully in discharge discussions (Change 7)

Ahead of the discharge system improvement plan review work we are aware that while significant progress has been made, there is still more to do. The focus into 2023/24 is on

- getting the acute processes timely (D2As prior to 12 noon), efficient (medication, transport arranged) and accurate (patient information) to ensure the hospital discharge team can act on the descriptions of individuals and discharge on the same day (Change 1, 2, 3).
- home first, specifically looking at VCSE home from hospital support operating alongside telecare and carers' support (Change 4, 5, 7)
- agreeing a hospital discharge SOP across our HCP (Change 3)
- working to implement OPTICA across our ICB to support with managing and overseeing flow, pathways and outcomes (Change 2).

National Condition 3 (cont)

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

All of the activity in this plan supports delivery of Care Act duties. A further few illustrative examples relating to core (non-exhaustive) Care Act duties are offered below.

Promote wellbeing (example)

The Council has developed its Wellbeing Academy which encompasses MECC - making every contact count. This approach is to enhance the wider public health workforce across Place, to enable staff, businesses, community settings and volunteers to work with individuals in a way that helps people to help themselves. This includes working with people to promote the aspects of their wellbeing that matter to them the most, to promote independence and enable people to access the right services. The skillsgate learning platform hosts the Wellbeing Academy and will be available to ICB staff at Place and wider external partners. The platform offers a certificate programme 'Creating Connected Communities' which hosts five modules for completion. Moving forward the platform will also host a number of wellbeing related e-learning modules. Further training including face to face workshops will be developed where appropriate.

Prevent needs (example)

The LiveWell site referenced earlier and in previous plans has been enhanced, and the digital self-assessment improved. Both are intended to provide information and advice to help people to help themselves. At the end of the self-assessment, individuals are provided with tailored information and advice, based on the answers given, and/ or the option to refer to the SPA. Contact information/ mechanisms for referral to additional support are also available. LiveWell/ the assessment will continue to be developed in the coming year(s) to maximise opportunities to promote independence.

Identify needs (example)

Accessible via LiveWell and separately, connectNEL(https://connectnel.com/) offers a free 24/7 signposting service which helps people identify whether they have needs, and signposts them to which activity or organisation across the voluntary/ statutory might be best placed to support them to meet those needs. This VCSE-led offer works in tandem with the more formal, statutory offer available via the SPA. Referrals are made between connectNEL and the SPA, as appropriate to identified need.

Respond to needs (example)

Workers discharging Care Act duties are embedded across community health provision (via CPG) and mental health provision (via Navigo), as well as within the lead social work provider (Focus Independent Adult Social Work). A single, defined practice framework will enable NELC and partners to share a coherent set of values, regardless of employer, and a belief system that will drive high standards of practice. It will provide clear expectations and a framework within which a consistent approach can be applied for practitioners, commissioners and providers. The new Social Work Task Force will help to embed the framework, and otherwise support improvements in quality of practice.

A concrete example of work intended to improve experience and outcomes is offered by recent work to support preparation for adulthood (PfA). This includes:

- Multi-agency group PfA working group, with parent/carer representatives re-established.
- PfA Protocol has been refreshed ready for relaunch.
- SEND (special educational needs) PfA lead Education, Health and Care Plan co-ordinator in post.
- Review of the Local Offer information on PfA is underway along with co-production of a parent/carer guide.

During the lifetime of the BCF plan we will:

- Deliver a communications plan to ensure all stakeholders understand their roles and responsibilities in PfA.
- Further develop integrated outcome focussed PfA processes, local provision and support that is informed by the views and needs of young people with SEND and their families that includes employment, independent living, friends, relationships, participation in the local community and optimal wellbeing.

Promoting diversity and quality in provision of services (example)
Good practice in market facilitation suggests that commissioners develop a common and shared perspective of supply and demand for care services. We also need to ensure sufficiency of provision, that the local care market is sustainable and fostering continuous improvement. These outcomes are likely to be helped by the development of a market position statement (MPS), which can be found here: https://www.northeastlincolnshireccg.nhs.uk/about-us/market-position-statement-mps/ The MPS reflects the priorities set out in this plan, and its timeframes are aligned.

The Market Intelligence and Failing Services Group ('the MIFS Group': see page 17 of our previous plan) comprises representatives from across health and care with expertise in a range of disciplines. The MIFS Group is able to instigate collective action in respect of failing or at risk services, to ensure that needs continue to be met through and beyond any period of provider difficulty. Acting as an effective 'safety net', the work of the MIFS Group both meets Care Act duties and helps ensure that the right care is delivered in the right place at the right time.

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 carers' agenda has been integrated since 2007, both in terms of the commitment to carers and the funding of carers' support and services. NEL offers supportive and inclusive universal prevention and wellbeing services to carers (specialist advice and information, peer support, activities and interest groups, the carers' emergency alert card, advocacy services, training, holistic therapies, counselling and small grants) meaning carers have access to a broad range of services without having a formal needs assessment. A significant proportion of these services are funded via the BCF. For those assessed carers with eligibility, they have access to carers' personal budgets and carers' breaks provision by providing replacement care to the cared for person.

The 2022/ 23 action plan was delivered as a multi-agency Carers' Partnership. Some highlights include:

- the launch of the dedicated carers' worker in the hospital, which in its first few months of operation saw a 400% increase in the number of carers identified and registered with the NEL Carers' Support service.
- the carers' dedicated specialist advice and benefits service has secured £1.5 million for our local carers in what would have been unclaimed benefits.
- Professor Grimes and the Street Law project worked with our local carers to support them to understand their rights and the law as it applies to them.
- Over 20 local businesses have this year signed up to the employers for carers and Carers UK initiative to support working carers and have adopted carer friendly practices.
- A carers' digital programme is encouraging carers to seek training and support on using computers and digital devices. As part of this we have loaned 70 carers a digital device to reduce loneliness and isolation.

Across the latter part of 2022/23 we undertook extensive consultation with carers and professionals to inform our NEL Carers' Strategy 2023-2026. Various consultation and engagement methods were used and the strategy document itself has been coproduced with carers. The strategy will be formally signed off in June 2023, to coincide with Carers' Week 2023. The priorities are:

- Identification, recognition & provision of information
- Workforce- culture & practice
- Access to assessments & support
- Carer education, training & employment
- Tackling carer inequalities
- Carer led.

The strategy is accompanied by a three-year action plan. The Carers' Partnership will work collaboratively to deliver these priorities across the lifetime of the BCF plan and beyond. Our most significant priority is the identification of carers who are not yet known to carers' support services, particularly focusing on seldom heard carers. Other priorities are to support working carers and carers in education (young carers and young adult carers) and well as further improving the robustness of the local carers' voice. In combination, the planned actions are intended to improve outcomes for carers.

Disabled Facilities Grant (DFG) and wider services

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

A Housing with Care Strategy is in development. This will review the needs assessment for accommodation with support in NEL for all adults. It is supported by partners in NEL (including housing and public health) and will involve discussions with residents and VCSE partners. The strategy will include commissioning intentions for care homes, extra care housing, supported living, supported accommodation, shared lives and housing related support including tenancy support networks. The needs assessment will be informed by public health population health management data and by a new Strategic Management Housing Assessment, completed by NELC Housing in early 2023. The first outline of the strategy is due before Autumn but in the meantime an improvement plan has been drawn up and is being delivered. Before the strategy is published there will be opportunities for engagement with stakeholders leading to proposed sign off by NELC Cabinet in January 2024.

DFG progress continues to be challenged by a shortage of Occupational Therapists (OTs) and Building Surveyors, which has an adverse effect on performance. To redress the situation, the Housing Assistance Policy was revised in January 2023, with some grant levels increased due to rising construction costs and other new grants introduced. Furthermore, a fast-track approach to progressing simple DFG applications was introduced and the Council and partners have agreed to introduce Trusted Assessors to help the OT service assess simple cases on the waiting list.

The revised Housing Assistance Policy includes support for hospital discharge, end of life care and dementia enabling people to live longer in their own homes. DFG assessments also include safe, warm and dry property checks, taking a holistic approach to improving living conditions and improving health outcomes, especially where residents suffer from a condition made worse by living in a cold home.

The DFG operational and strategic groups continue to meet monthly with partners from social care, housing, health and finance from across the local authority and ICB to identify improvements to the DFG process, as well as monitor performance and expenditure.

In the next two years, we will:

- Increase the surveying and OT capacity on a temporary basis to help reduce waiting times.
- Develop new processes with the main Registered Providers to enable them to install their own DFGs using their own contractors whilst ensuring value for money, thereby considerably reducing the waiting list (by a third).
- Develop the scope of the handyperson service to respond to holistic housing needs assessments including thermal warmth, sustainable energy, securing loose carpets, and other repairs and maintenance around the home.
- Develop a trusted assessor approach to adaptations, delivering a more direct service and reducing OT waiting times.
- Work to support those who have waited for suitable adapted housing on our home choice links register by acquiring housing stock from social landlords and adapting it as appropriate.
- Enable trusted assessors to work with the Homelessness Team to find suitable accommodation for households living in unsuitable properties that no longer meet need and cannot be adapted.

These initiatives will ensure that DFG money is used to support people to stay well, safe and as independent as possible in their own homes. Speeding up DFG application will help people to continue to be supported at home, which for most DFG applicants, represents the right care in the right place, at the right time.

Additional Information (not assured)

Having you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to use a proportion of DFG funding for discretionary services? Y/N?

Yes.

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

£ 550,000

Through the revised Housing Assistance Policy, which was agreed in January 2023, funding will be made available for new grants to support residents to live in their home for longer. This includes (but is not limited to) dementia support, fast track grants and increasing grant amounts, where it is not feasible to move the occupant to alternative accommodation. The Council will benchmark budgetary data in year one for future years.

Please note that NELC is a unitary authority, so no districts use this funding.

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.

Introduction

NEL's approach to tackling health inequalities remains largely as set out in previous plans (see last year's plan at page 23 onwards). Our previous plan gave significant attention to NHS Priorities and Operational Planning Guidance and the CORE20PLUS5 approach, all of which is intended to continue during the life of the current plan. Broadly, 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. By way of update on examples of the ways in which services seek to take support to users, as given in our last plan, we offer the following:

- The introduction of mobile technology to undertake physical health checks has seen an increase in the number of health checks for people with a serious mental illness. There is still further work to continue and make further improvement – which is planned to implement this year.

- Liaison workers in Primary Care have proved effective for people with serious mental illness. It is planned this year to extend the approach to people with dementia like needs, adding another approach to supporting people to maintain connectivity and thereby support delay in progression of their condition.
- A further improvement plan is focused on improving information and accessibility of information where people have concerns they may have dementia. A re-focussed Dementia Support Service contract is to be procured in this year, enabling support before and through the diagnosis process as well as support and information in managing life with dementia afterwards.
- The number of people with a learning disability who have had a health check has exceeded the target, however it has highlighted a group of 'hard to reach' people. Supplemental resource and plans have been put in place to enable health checks to be completed in individuals' own homes, using mobile and remote technology to support workers.

BCF funds are used to support the Assisted Living Centre (ALC) referenced in previous BCF plans and at page 5 above. Amongst other objectives, the ALC seeks to address the inequalities or barriers arising from physical or mental disability, and support individuals to live as normal a life as possible. The ALC does this by providing advice on a range of equipment to help in the home, including wheelchairs, hoists, walking frames and home adaptations such as stair lifts. The ALC's community equipment store offers a loan and return scheme and a demonstration area allowing people to see how items could work for them at home. The ALC is staffed by occupational therapists able to assess for NHS-eligible needs and offer guidance on purchases outside of that. Assessments are bookable via the SPA or available by drop-in between 10am-6pm on weekdays and 10am-4pm on Saturdays.

Changes

As mentioned in our previous year's plan, following the establishment of ICB and HCP, the Union Equality & Diversity Core Group has become the HCP Equality, Diversity & Inclusion (EDI) Group. As planned, the EDI Group's membership has been broadened to include more local partners, and will build on the work of the Union E&D Group.

The Group's core tasks continue as set out previously (see last year's plan at bottom of page 25). One of these tasks was to oversee relevant training. Since creating our last BCF plan, options for training have been identified. These will be explored further at a workshop in June, following which a decision will be made on the best option to proceed with. The Group will then plan a programme of training delivery for roll out during the lifetime of the current BCF plan.

It has further been agreed that a key task for the Group is to develop a place-based vision, strategy and implementation plan, to ensure that objectives are clear, and efforts are properly coordinated and targeted. Once this vision/ strategy/ plan is developed it will provide a framework for EDI work during the lifetime of the BCF plan and beyond.

The EDI Group will link with the Population Health Management Advisory Group. This latter group is being established under the Joint Committee to take forward a population health management strategy, with a focus on addressing health inequalities. NEL was part of the NHS England Population Health Management Accelerator Programme established in 2020, and aims to build on the learning from that during the lifetime of the BCF plan. The ICB is making investments in Place-based public health in order to address health inequalities and the Council is establishing some targeted programmes of action in some of NEL's poorest communities. The aim is to improve health

outcomes in those communities, with a particular focus on improving health in early years, addressing tobacco dependency and identifying early signs of chronic illness in people in midlife.

Consideration of impacts
New and/ or revised Place-based policies, strategies and services are accompanied by an Equalities Impact Assessment (EqIA). Each EqIA comprises an outline of the policy/ strategy/ service's intentions, and detail of any anticipated impacts by reference to each protected characteristic. EqIAs are refreshed periodically.

The EqIAs are reviewed by a Community Equality Impact Assessment Panel, intended to provide a check and challenge to the assessment. The Panel is made up of local people with an interest in equality and diversity who volunteer to help us consider how our plans may impact on groups who share a protected characteristic. They are not experts on equality and diversity legislation or practice, but provide a community perspective from their own lived experience.

Whilst the overall BCF plan has not been the subject of a EqIA a number of its component parts have; for example, the Carers' Strategy referenced above (see 'supporting unpaid carers' section) is accompanied by an EqIA to ensure that otherwise unidentified impacts for all types of carer are properly acknowledged and addressed. The Carers' Strategy sets out the local plan to support carers, including via services and support funded by BCF. For example, BCF monies support work to target carers attending the local hospital (to ensure they too are supported at the discharge of their cared-for person) and to ensure referrals to the Carers' Support Service, which also receives BCF funds. It is known that carers are twice as likely as their non-carer counterparts to suffer ill health and have less access to work/ training/ social/ leisure activities due to their caring role. Therefore, by identifying, recognising and supporting carers we are helping to reduce their health inequalities.

Addressing impacts
As noted in our previous plan (pages 7 and 25), the joint engagement strategy entitled 'Talking, Listening and Working Together' (TLWT) (https://www.northeastlincolnshireccg.nhs.uk/data/uploads/engagement-strategy/twlt-final-digital-a11y-accessible.pdf) sets out the NEL Commitment to routinely involving communities, talking to the public as early as possible and being informed by their experiences, concerns and aspirations. One of the reasons for engaging with communities in this way is to enable the identification of potential unidentified impacts on communities with protected characteristics, and seek to address those in evolving service design.

Initially launched as a joint CCG/ Council strategy the NEL Commitment set out in TLWT has since been adopted by the HCP, its terms of reference refreshed to reflect this and composition of the strategy steering group expanded. The steering group, which meets quarterly, has identified a number of key priority areas to focus on over the next two years including:

- Launch of the TLWT engagement toolkit which sits on the Place website Livewell and is publicly accessible. The Toolkit contains statutory guidance, tips and local case studies to share good engagement practice
- Embedding the NEL Commitment and Toolkit into corporate induction for Council and partner organisations
- Development of an Engagement Calendar and activity planner to enable organisations to identify opportunities for joint working and avoid duplication of activity
- Continuing creation of a programme of engagement activity, intended to offer a variety of opportunities for community members and VCSE colleagues to contribute to Place development

- Further development of a partnership approach to planning and designing services with the establishment of the NEL Mental Health Alliance, community dementia pathway group, household grant schemes and food poverty initiatives. Both a Dementia Strategy and Mental Health Strategy are in development. The Mental Health Strategy is currently being co-produced with experts by experience and is expected to be published in September 2023. The resulting programme of work will be led by the Mental Health Sector Network and delivered by a variety of working groups with members from across the HCP.

These actions are crucial to harnessing and utilising the views of those from all communities, including the harder to reach.