Appendix

Sunderland Better Care Fund Narrative Template 2021/22

Health and Wellbeing Board(s)

Sunderland Health and Wellbeing Board

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

The Better Care Fund in Sunderland is aligned to the scope of services in All Together Better (ATB), the alliance of commissioners and providers in Sunderland to deliver the most personalised, pro-active and joined up care possible. All providers of adult out of hospital care are a member of ATB and have signed up to a compact to work together for patients of Sunderland and in the best interests of the system. Partners include NHS trusts, social care providers, voluntary care providers, mental health providers and commissioners. All programmes with ATB have representation from all key partners who are involved in developing the plan which underpins the BCF.

The Operational Plan for ATB has been developed by ATB in conjunction with commissioners and providers and regular engagement into transformation/priorities is undertaken with all key stakeholders.

https://atbsunderland.org.uk/

ATB have an agreed communication and engagement strategy to ensure that all providers and stakeholders are engaged in the development of plans and involved in relevant transformation.

Executive Summary

Sunderland has a long history of integrating health and care services in the city through partnership working and co-production. The All Together Better collaborative has been in place since 2015 and, through the unified vision and combined efforts of both health and social care commissioners and providers, has had significant success in addressing the key challenges of promoting health and wellbeing, delivering better outcomes for patients/service users and promoting ease of access.

Locally and nationally the system is facing challenges around Covid recovery, sustainability and changing population needs.

Historically, care has been constrained by organisational and professional boundaries, resulting in reactive, fragmented and inefficient care. This often resulted in:

- People and families being moved around the system with multiple hand-offs between health and care professionals
- Different care teams assessing and diagnosing people reactively and separately, often asking the same questions and doing the same tests
- Information not always being shared or available across organisations and sectors
- Separate teams responding to people and families rather than offering proactive co-ordinated care
- Little emphasis on self-care with clear escalation routes
- Physical health needs often focussed on, with emotional needs being overlooked
- Failing to make best use of the people's own resources and resilience, or those of wider partners such as education and social networks.

To achieve our ambition for Sunderland we have developed a model of care for the local health and social care economy with six key priorities.

- **More effective prevention** – through enhancing community resources and resilience. Delivering proactive care is holistic and preventive, empowering people to play a central role in managing their own care, preventing onset or decline of care needs or conditions. Bringing health and care services together in one coordinated care response that is underpinned by prevention, self-care, early intervention, reablement and rehabilitation can avoid long term treatment and life-long service dependency.
- **Delivering integrated care more effectively** – enhanced Primary Care will be targeted towards people who have one or more long term health condition, and who depend on support, but who are not counted among the frailest in the city.
- **A locality-based, community-focused delivery model to reduce health inequalities** - All Together Better has demonstrated the importance of better co-ordination of care across teams and organisations. The multi-disciplinary approach adopted by our Community Integrated Teams (CITs) and the Recovery at Home Service, working closely with PCN's has enabled a marked shift away from reactive care to proactive care.
- **An approach to care that seeks to maintain stability and prevent escalation** to more acute levels of care with greater use of the third sector to promote this change.
- **Maintaining flow and capacity in urgent and emergency care** is vital to maintain stability within the system. Sunderland has made significant progress in developing a range of services to effectively manage pathways 0 – 3. Alongside this both acute and community health and social care staff have adapted ways of working to support the discharge to assess

model. Nevertheless, we still recognise that there is further work to do over the coming year.

- **A focus on staff well-being, recruitment and retention.** There are a number of workforce challenges in the system at the moment. Staff across the system have been tremendous in ensuring we navigated through each wave of the Covid pandemic. We recognise the impact this had upon staff and a number of well-being initiatives have been implemented. New and innovate approaches are being developed to address the recruitment challenges within adult social care and reposition the sector as somewhere that individuals can have a successful, flexible and rewarding career.

The above priorities build on those of the previous BCF with an added emphasis on embedding newly developed community services and putting in place permanent a more permanent operating model to meet the needs of the local population and ensure a smooth transition to the North-East and Cumbria ICS. To test out new approaches to provider and commissioner collaboration we have agreed to cope new approaches in three pilot areas.

- Mental health strategy integration
- Learning disabilities and autism
- Local GP Contracts

Governance

The scope of the Sunderland BCF is aligned to the scope of ATB in Sunderland with pooled funds aligned to the five programmes of ATB which are:

1 – General Practice

2 – Mental Health, Learning Disabilities and Autism

3 – Enhanced Primary and Community Care

4 – Intermediate and Urgent Care

5 – Integrated Health and Social Care

The ATB Executive Group is the pooled fund manager and is responsible for the overall integrated delivery, performance, outcomes and general oversight of adult out of hospital care. Consisting of both providers and commissioners, the executive group ensures that appropriate arrangements are in place to deliver its delegated functions effectively, efficiently and economically. It is a formally constituted group with the responsibility to:

* Lead the strategic development of the alliance

* Oversee the transformational programmes

* Ensure engagement and transparency in decision making at all times

The executive group has a terms of reference which sets out its roles and responsibilities to achieve its agreed vision and objectives of out of hospital services in Sunderland in line with an agreed scheme of delegation. The executive group meets monthly and is chaired by a GP with a Managing Director to oversee the day-to-day delivery of operational duties. The GP Chair is also a member of the HWBB. The executive group provides assurance on ATB's finance and governance systems, financial information and compliance with laws, guidance and regulations governing the NHS in so far they relate to ATB. It has an assurance and performance and outcomes framework in place to support this governance framework.

The overall responsibility for oversight of the operational and financial delivery associated with the BCF plan in Sunderland will be joint with the Council and CCG. Delivery of the BCF plan will be via the ATB executive committee which includes the BCF metrics which are aligned to ATB and included within the ATB performance and outcomes framework and transformational change programmes

Overall approach to integration

The BCF for 2021/22 continues to underpin our collaborative commissioning arrangements in Sunderland with the scope of the BCF aligned to the scope of All Together Better (ATB), all adult out of hospital care. The scope of ATB (and BCF) is organised into five key programmes and a city-wide Neighbourhood Group, focusing on developing a neighbourhood operating model.

The ATB Operating Plan for 2021/22 sets out the vision and priorities for 2021/22, aligned to the BCF. This was developed and agreed and includes priorities agreed prior to the pandemic and as a result of the pandemic e.g., discharge and crisis response and also takes into account delivery of the national planning expectations for H1 and H2 for 2021/22.

Operational%20Pla
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Our approach to integrated commissioning is also developing as we transition to a new commissioning landscape from April'22. A Sunderland Integrated Care Executive has been established with Chief Executive representation from several key partners across the Sunderland system including Sunderland CCG, Sunderland City Council and NHS Provider Organisations. The Executive will lead and support the development to the transition to new place-based arrangements within Sunderland resulting from the establishment of the ICB from April'22.

In August'21, a Transition Steering Group (TSG) was formally established to put in place these arrangements as soon as possible with key workstreams in place to deliver Sunderland place-based partnership arrangements. This includes governance, finance, provider collaboration, commissioning development and business intelligence and leadership and people. Further opportunities have been identified to help improve health and care outcomes by working differently as a system (commissioners and providers). It is through working differently that we will learn and make recommendations for the future in relation to how we integrate commissioning and provision.

Three additional priorities have been agreed which are:

- Mental health strategy integration
- Learning disabilities and autism
- Local GP Contracts

As part of local and ICS assurance around delivery of national planning priorities, regular assurance is provided to the CCG and ICS around delivery at place and ICP level.

Supporting Discharge (national condition four)

ATB and SCC work alongside the Clinical Commissioning Group (CCG) to improve the level of integration between health and social care in the city with a particular focus on timely discharge from hospital to appropriate community settings. Over recent years this has afforded investment in reablement and recovery at home services, alongside other areas. Pressures in the hospital system and in particular the national Discharge to Assess mandate have resulted in significant numbers of additional people being discharged from hospital into 24 residential care or requiring significant support packages to remain in their own home post discharge.

In response several short-term support services and longer-term initiatives have been developed to meet the increased acuity of people being discharge from hospital. Examples include:

- Enhanced community therapy services to support people on a reablement pathways
- Newly created therapy team to support people in residential and nursing homes
- Increased use of personal assistants to support non-complex discharges
- Use of automated telephony post discharge for Pathway 0 patients and carers to identify and offer early interventions and proactive support post discharge where appropriate
- Use of automated telephony post reablement discharge as an early identification opportunity to intervene and offer individuals and carers proactive support
- Expanded role of VCS to support people in the community post discharge
- Significantly increased social work and nursing resource to enhance Integrated Discharge Team.
- Commissioned additional capacity in the market for bed based reablement for pathway 2 discharge
- Put in place a multi-agency Care Home Group to ensure the voice of the independent sector is heard and that providers feel better support and able to influence system decisions.
- Implemented a very senior decision making and oversight group to support rapid decision making in times of pressure and escalation. This is supported by the appointment of an independent System Co-ordinator post.
- Enhanced support for carer's who may be called upon to increase their level of support to their loved ones. This includes promoting the take up of carer assessments.
- Enhanced communication for Carers within the hospital discharge process

The additional funding available to support hospital has been invaluable to support the development of new services and expand traditional provision. Additional winter/surge funding has also been agreed across Sunderland as part of the winter plan, this includes additional support for discharge and flow through the system.

Additional winter funding has been allocated to the following schemes:

- Increased capacity and improved coordination for the Integrated Discharge Team
- Additional resources into the rapid response home support team
- Additional surge capacity for general practice
- Increased staffing and capacity into front and back of house within STSFT and the Urgent Treatment Centre
- Additional transport to aid timely discharge
- Additional palliative support to help timely discharge and prevent admissions.

The BCF through its programmes has been delivering focused projects linked to enhancing safe discharge pathways. This is being monitored through a local surge group and being operationally managed through the ATB. Further work is underway to understand the recurrent funding requirements for discharge pathways into 2022/23 and a programme of work is underway to confirm funding allocations from the CCG and LA into the pathway following the cessation of hospital discharge funding from the treasury on the 1st April 2022.

Physical health is not the only focus of our plans, we continue to utilise local and national funding to support patients who are discharged with mental health problems. ATB P2 is in the process of agreeing additional plans to utilise national funding to support mental health discharge and to support patients. This includes additional accommodation and support packs on discharge.

Disabled Facilities Grant (DFG) and wider services

In addition to a significant investment in traditional DFG's, Sunderland has a strong emphasis on the use of assistive technology in housing for citizens and staff and increasing the level of affordable homes in the city that meet the needs of vulnerable and at-risk groups. This includes more specialist accommodation, further Extra Care schemes and adapted bungalows. This is being co-ordinated through a dedicated team in the Local Authority and underpinned through a capital budget of £59m. The most recent development, Albert Place, provides a number of cat 3 bungalows to support individuals to live independently. Each bungalow is fitted with a range of smart technology and sensors that allow a blended approach to care.

Alongside Public Health, affordable warmth is a key priority for the city and a range of initiatives are in place to address this. Most recently the LA has been chosen as a Digital Catapult to test out approaches to using technology to tackle damp.

Sunderland has an ambition to be a truly smart city with no-one left behind. A recent partnership has been launched with BAI to ensure high speed connectivity is available to everyone and will facilitate the roll out of technology enabled care into people's own homes. A project is underway to look at a combined approach to telecare and planned underpinned by technology care to develop a more responsive approach to care in home settings and truly meeting the ambition of the right care, in the right place at the time the customer chooses.

Equality and health inequalities.

The BCF for 2021/22 remains aligned to the scope of All Together Better (ATB), all adult out of hospital care in Sunderland. Our collective focus remains on the people we serve, on doing the right thing, protecting the vulnerable and making sure patients have access to the right support and care when they need it. This has been further strengthened through the pandemic and recovery period and is testament to the way health and care partners across the city work together.

The pandemic has without doubt exposed health inequalities even further and we know that some parts of our communities have been negatively impacted more than others. Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. They arise because of the conditions in which we are born, grow, live, work and due to our age. These conditions influence our opportunities for good health, and how we think, feel and act. This shapes our mental health, physical health and wellbeing. Addressing health inequalities was already a priority for Sunderland, but the inequalities further exposed by COVID-19 now means we must work harder than ever to close the gaps that exist. We must make sure everyone has access to the same high-quality care.

In Sunderland we have a Healthy City Plan which underpins our approach to health inequalities and tackling the social determinants, 'the causes of causes' of poor health throughout the life course – starting well, living well, ageing well and addressing inequalities for key vulnerable populations.

https://www.sunderland.gov.uk/media/23331/Sunderland-Healthy-City-Plan-2020-2030/pdf/M0103076_HEALTHY_CITY_PLAN_2021.pdf?m=637584173389400000

In 2020/21, a number of recovery principles were agreed across Sunderland. A key principle was to ensure that any changes in service provision do not result in increased health inequalities. This has led to the development of a greater understanding and focus on population health and what it means to Sunderland. In 2021/22 we have further developed our approach to population health, segmenting our population for the key ATB outcomes, some of which are aligned to the BCF metrics for 2021/22. This includes analysis of all key outcomes (including the BCF metrics) locally by index of multiple deprivation to help address health inequalities and equality.

Sample reports that are developed by ATB on behalf of Sunderland which is segmented by PCN and also IMD, focusing attention on the need to understand and tackle health inequalities.


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Projects within the scope of ATB (BCF) are required to have a full project outline document to be signed off by the programme group (SRO and SRC) and ATB Executive (Including finance and contracting staff). These documents have screening tools embedded which also require sign off by leads. These include:

- Quality Impact Assessment
- Equality Impact Assessment
- Data Protection Impact Assessment
- Health Inequalities Heat Tool

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Screening tools are available to guide the project team to understand whether full impact assessments are required. Locally, a Joint Strategic Needs Assessment (JSNA) group has been established which includes the CCG, Council, Public Health, ATB and providers. This group is leading the identification and coordination of JSNAs across Sunderland which includes the approach identifying health inequalities.

The metrics developed in the Sunderland BCF plan have been supported using data through a health inequalities lens. This data will be used going forward to help shape the developments around discharge and avoidable emergency admissions. Using local data, historical actual levels for the avoidable admissions and discharge metrics have been analysed using deprivation decile to identify the impact of deprivation on patients. There is a difference in the proportion of patients discharged to their usual place of residents between the most deprived and least deprived communities, some months this is a difference of up to 6%. This will be a key part of the work going forward as we develop our integrated discharge arrangements. There is no material difference in long lengths of stay but this will be monitored closely as part of our approach to understanding the impact of health inequalities on our communities.

The BCF metrics will be monitored via established Performance and Outcomes reporting via ATB going forward and will be reported to ATB Executive Group and via ATB assurance to the CCG.

Better Care Fund Metrics

2021/22 remains a challenging year in the Sunderland system and this is replicated regionally and nationally. The urgent care system is particularly challenged and the requirement to manage both COVID and non-COVID flows, alongside a challenging elective care recovery programme provides additional complexity.

As a result of the challenges, surge arrangements have been put in place which includes senior level ATB surge arrangements. The ATB operational plan details a number of the transformational projects that have been agreed to deliver real change in the Sunderland system, some of which are already building on best practice such as crisis response.

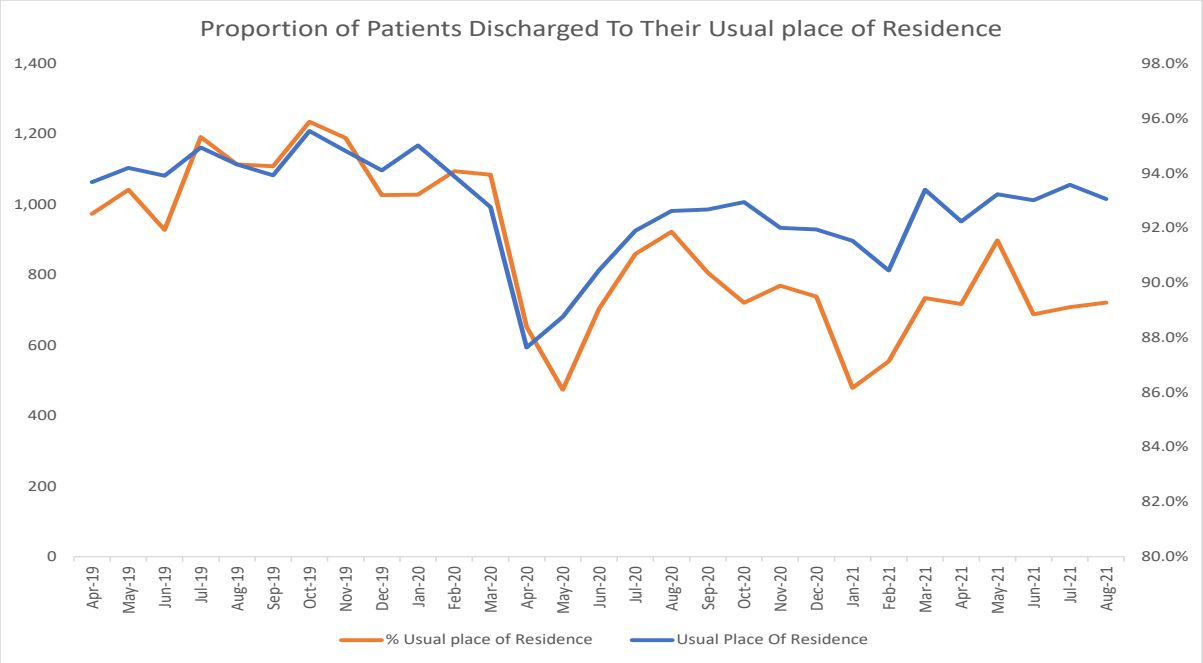
Development of the BCF trajectories has been built on the ATB approach which includes engagement with NHS Trusts, VCS and other stakeholders and where transformational projects are in place, metrics have been developed based on the plans already in place e.g., discharge.

Discharge Metrics

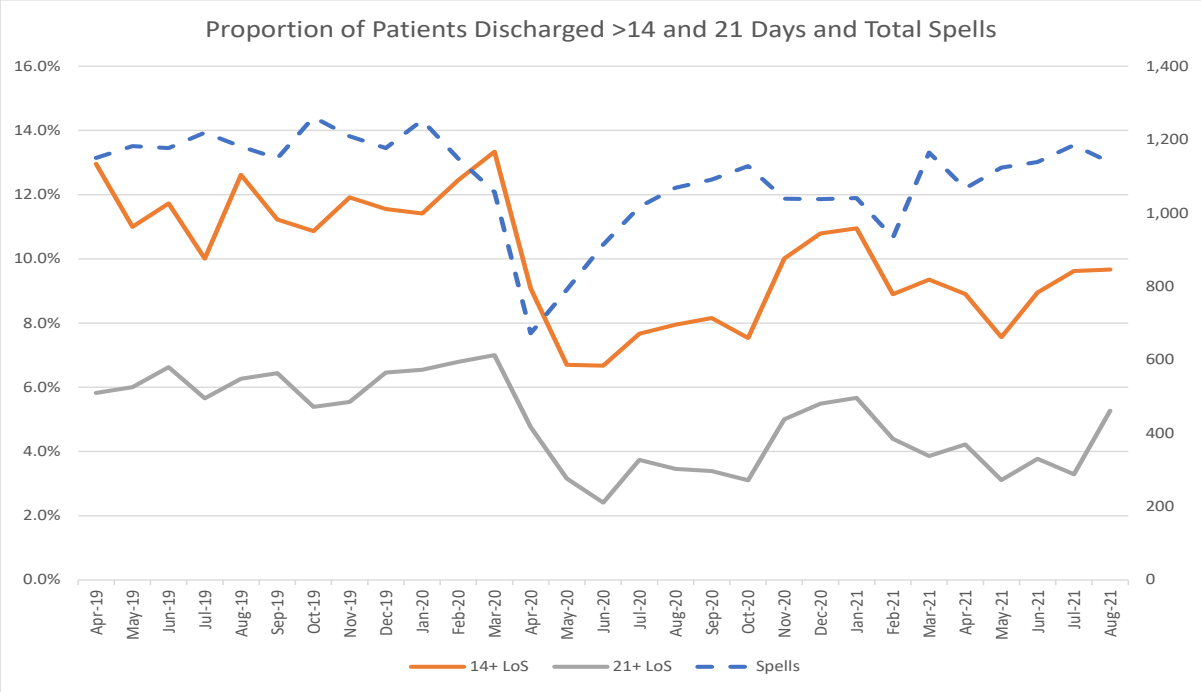
Sunderland has been a high performer in terms of discharge which included previous BCF metrics around delayed transfers of care.

Prior to the pandemic, performance against the discharge to usual place of residence metric was comparable to the England rate and in some instances higher. The impact of the pandemic clearly had an impact on the number of patients discharged to alternative destinations which was direct correlation to the national discharge policy. This is also a consequence of people coming out into the community that have higher levels of acuity which is often met with a bed-based solution in the community.

Due to the pressures we are encountering now and expected to increase over the winter period, the expectation is for the proportion of patients discharged to their usual place of residence to be maintained at current rates.



The same can be said of the number of long stay patients in hospital. Again, Sunderland historically has been a high performer and the impact of COVID had a positive impact on the number of patients in hospital >14 days, again in line with national policy direction. As the system recovers and pressures have built up, the number of patients waiting longer in hospital has increase but is not up to previous levels. Due to the significant work around discharge outlined earlier in the narrative and additional winter funding, the focus is to maintain current good performance for both 14+ and 21+ day LoS. This is based on seasonally adjusted forecasts when setting the trajectory.



Reablement

The actual for 20/21 was 61.4% and this was due to numbers of individuals dying passing away within 91 days and those being admitted to permanent care doubling in comparison to previous years. The plan for 21/22 will be to start to improve this figure to reflect a 5% increase as well as increase the actual numbers who receive reablement via the reinstatement of the recovery @ home service which has been used for short term service provision since COVID commenced to aid hospital discharge as outlined in the discharge narrative.

Residential admissions

A direct impact of Covid and changes to national hospital discharge policy has seen more people discharged from hospital with much higher levels of need requiring 24-hour care. Work is ongoing via the ICP and ICS to enable greater integration of care with a focused approach around early intervention and prevention using data modelling techniques to identify individuals who present with factors that make them more vulnerable to frailty and ensuring they are engaged and supported at the earliest opportunity. The use of Per and DP are being considered and broadened to enable a more tailored and personalised approach for individuals where permanent care may previously have been considered as the only option building on successful frameworks.

Ambulatory Care Sensitive Conditions

The impact of COVID is evident on emergency admissions in Sunderland and nationally. The current trend is a concern due to the pressures across the system and we continue to work collaboratively to

manage the demands in the system. There was a significant decrease in ambulatory care sensitive conditions (and total emergency admissions) during the pandemic and there the current trend shows that the previous growing trend is continuing after the pandemic in 2021/22. Given the challenging winter thus far and the expected increase in demand in the urgent care system, it would be unrealistic to maintain current or historic levels or emergency admissions. Thus were are expecting an increase to above 2019/20 levels but to reduce the level of growth being seen.

ATB P4 priorities include national priorities around urgent and intermediate care which include the implementation of crisis services which Sunderland already has in place. Currently around 80% of contacts are seen within 2 hours but work is ongoing to implement this in line with national expectations in quarter four. This includes engagement with ED to help reduce admissions and engage with Community Integrated Teams for a proactive approach to managing care. Additional winter support and the colocation of the UTC in ED have been agreed to help manage some of the pressures in the urgent care system. Due to the increasing trend in emergency admissions both nationally and locally, the trajectory for the latter part of 2021/22 is to try and mitigate some of the growth.