HM Government

NHS England

BCF narrative plan template

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

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

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

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

Integration and
Better Care Fund

Cover

Health and Wellbeing Board(s).

Stockport Health and Wellbeing Board is a committee of Stockport Metropolitan Borough Council required by statute. Whilst the Board is formally a statutory committee of the Council, it operates as a multi-agency board of equal partners and provides a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities.

The responsibilities of the board are quite broad but are mainly focused on co-ordinating the Joint Strategic Needs assessment (JSNA), publishing a Joint Local Health And Wellbeing Strategy (JLHWS), which sets out the priorities for improving the health and wellbeing of the local population and how the identified needs will be addressed; addressing health inequalities; and reflecting the evidence of the JSNA directly informing the development of joint commissioning arrangements for Stockport and co-ordination of NHS and local authority commissioning, including the Better Care Fund plan. The Board has a duty to develop the local pharmaceutical needs assessment.

Membership of the Health and Wellbeing Board include leaders across the NHS, Social Care, Public Health, Healthwatch and other services directly related to Stockport operating as an integrated locality focused on inequalities and collaboration.

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

- NHS Greater Manchester Integrated Care
- Stockport Metropolitan Borough Council
- Stockport NHS Foundation Trust
- Stockport Homes
- One Stockport Health and Care executive which includes VCFSE representatives, and Healthwatch

How have you gone about involving these stakeholders?

The One Stockport Health and Care Board, our Locality Board, and the Stockport Health and Wellbeing Board agreed to undertake a review of the Better Care Fund (BCF) as a system. The Locality Board agreed that we would set out an approach to undertaking the review on outcomes and spend considering the national refocus on the BCF and particularly on the BCF policy objectives as well as considering the aspirations of our joint local plan, the One Health and Care Plan, which is jointly owned by the Health and Wellbeing Board acting as the statutory Joint Local Health and Wellbeing Plan.
The review was undertaken from November 2022 to March 2023 which was supported by a wide team involving colleagues from NHS GM and SMBC as well as the Local Government

Association. This review has been underpinned by collaboration, transparency and participation of key stakeholder and partners. It has provided an opportunity for diligence against the national conditions and to provide assurance of its use and identification for greater alignment against the policy objectives.

Governance

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

The Health and Social Care Act 2012 placed a duty on the local authorities to establish a Health & Wellbeing Board (HWBB) that brings together representatives of the Council, Stockport Clinical Commissioning Group (now NHS GMIC), Stockport Healthwatch and key statutory officers to provide strategic leadership over commissioning health and social care services in the borough.
The role of Stockport Health and Wellbeing Board in the governance of the BCF is to review and approve the plan prior to submission to national colleagues.

Executive summary

This should include:

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

Our priorities for the Better Care Fund in 2023/24 are reflected in our submitted plan.

There was agreement as part of the BCF review that the system in Stockport would focus collectively on making best use of our existing BCF funds in the following key priority areas:

- More focus on Out of Hospital provision
- Reablement (better utilisation of current capacity through the Reablement Service)
- A focus on tech-enabled care through better utilisation of Disabilities Facilities Grant
- A more collaborative approach for family carers

The system in Stockport remains committed to maintaining and developing our home first ethos through supporting individuals to remain independent and ensuring people receive the right care in the right place at the right time. In line with our Locality Board objectives, we will co-ordinate the whole system to identify which pathways that intersect across the interfaces of our various services can be optimised in a more integrated, coordinated way drawing on the Core20PLUS5 approach.

The ethos is on maximising individual independence at all times and reducing dependence upon long term care wherever possible.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Embedding integrated, person centred health, social care and housing services is a key component of our approach in Stockport. As mentioned earlier in the document we have recently undertaken a review of our BCF. The review was a truly collaborative conglomerate of partners from across the Stockport system meeting around themes of quality, workforce, collaboration, access, as well as sustainability and finance. The approach really exemplifies our strong emphasis on joint commissioning; not just between NHS GM and SMBC but more broadly with housing partners as well as patient voice, mental health providers and acute providers.

The Working Group that led the review have consolidated the feedback from the partnership events and have proposed some changes to the way that BCF funds are utilised; this would be characterised by a collective focus on making best use of our existing BCF funds in the following key areas:

- More focus on Out of Hospital provision
- Reablement (better utilisation of current capacity through REACH)
- A focus on tech-enabled care through better utilisation of Disabilities Facilities Grant
- A more collaborative approach for family carers
- Implement national guidance for the Better Care Fund 2023/24 and align agreed focus from review with new plan.

This aligns to our Locality Board objectives, membership includes the more traditional health and care partners as well as Greater Manchester Police, Stockport Homes and the senior representation from Healthwatch and the wider VCSFE sector. The objectives:

- People are Happier and Healthier, and Inequalities are reduced
- Our population has access to safe, high-quality services which make best use of the Stockport pound
- Everyone takes responsibility for their health with the right support
- Local social and economic development is supported

With regard to further supporting the improvement of outcomes for people in Stockport, we will continue to work collaboratively to drive the priorities established through the BCF review. This will ensure that the system has the services required and is able to deliver against the agreed priorities and evolving challenges, overseen through analysis of key data across the system.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

It is a key component of the One Stockport Health and Care Plan to support people to remain independent by keeping them well at home, avoiding an unplanned hospital admission wherever possible.
Where an admission is necessary, we are focused on ensuring that people only stay in hospital for the period that they medically need to and have a safe and timely discharge home (with or without a package of care).

The vision for Stockport is to work together as ONE system, wrapping care around the needs of the person. We will work together to create a sustainable, person-centred system where professionals work together with local communities to prevent ill health, proactively support people to remain independent and offer high quality care when needed. This will be achieved through the development of a new Neighbourhoods and Prevention Programme for Stockport, of which the Out of Hospital care Model will be a key constituent. Many parts of our system will be key to delivering on the programme, particularly our Primary Care, for many the front door of the NHS; some of this will be delivered through the Primary Care Blueprint as well as preventative initiatives at the heart of the wider programme. All partners will play a part in working together in an integrated way with agreed pathways to support people to keep well and as independent as possible. Primary care, community health and adult social care and the voluntary sector working together for the person.

The Out of Hospital Model in Stockport will be characterised by four key components:

- A model enabled by Wider Public Service Reform
- Integrated Pathways and Interfaces – at Neighbourhood and Place level
- Proactive Prevention – Population Health Improvement Plans at PCN-level
- Proactive Prevention – MDT and Case Finding at Practice-level

Stockport has a range of primary care services are funded through the Better Care Fund to prevent attendances to our emergency department and to prevent avoidable hospital admissions. This comprises various schemes including providing extended hours, additional care home support above the requirement of the enhanced health in care homes network DES, home visits as well as enhanced management of long-term conditions. It is a core element of our approach of enabling people to stay well, safe and independent at home for longer that we ensure that our services are person-centred, streamlined and integrated around

the patient. The BCF supports investment in to integrated health and care teams in neighbourhoods. Each Neighbourhood Team wraps around a number of GP practices and their populations. Our multi-disciplinary teams are made up of district nurses, community matrons and intermediate care professionals and social workers along with the existing GP practice staff.

Services are provided by the teams in a variety of settings, principally the persons own home but delivering some interventions in other locations such as GP practices, community clinic locations or residential/care homes to meet the needs of individuals. The skill mix and capacity of the teams within the neighbourhoods will vary to meet the particular health needs of each neighbourhood, proactively where possible and allow maximum flexibility in resource allocation. The Community Neighbourhood teams will be expected to utilise relevant care pathways to deliver integrated care including but not limited to:

- Rehabilitation and maintenance
- End of life care
- Urgent care services
- Falls
- Community beds (step up/step down)

All these pathways are based on an asset based approach which is fundamental to the approach in Stockport. In line with our prevention approach, the BCF also supports our Crisis Response Team (CRT) which is commissioned to reduce unnecessary hospital admissions and prevent avoidable Emergency Department (ED) attendances. The approach is to provide holistic multidisciplinary interventions and support stabilisation for patients in their own home or usual residence. The CRT is a multi-disciplinary integrated team consisting of highly skilled senior nurses, occupational therapists (OT), physiotherapists, Social Workers and support workers, working where relevant in collaboration with the Mental Health Liaison Team. Initial assessment is carried out within 2 hours, the aim is to avoid admission and stabilise patients within 72 hours, if after these 72 hours of care on-going support is required then referrals will be made for support from the appropriate services in the neighbourhoods.

We will co-ordinate the whole system to identify which pathways that intersect across the interfaces of our various services can be optimised in a more integrated, coordinated way. This approach dovetails with the support offer for carers and our housing adaptations approach as a fundamental part of supporting people to stay well, safe and independent at home for longer.

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.

In reviewing the performance across 2022/23 the system partners highlighted variances against regional and national averages as well as looking at the specific pressures, challenges and systems in Stockport. Avoidable admissions into hospital is on target and is lower than the GM/NW average but higher than England. It was also noted that the average length of stay in both acute and residential sector is higher than the regional and national averages and has been exacerbated by the lingering effects of the pandemic.

It is evident that Stockport performs slightly below national and regional averages for D2A. Our drive to support people to return home via pathway 1 will incorporate increased capacity and through engagement with providers, market conditions with Pathway 1 capacity provide confidence that performance will improve.

Having reviewed the approach over the past year, Stockport has set challenging targets to reduce permanent admissions to residential care and whilst the data on these measures are below the regional and national averages this is an area of continued focus locally. The reablement service has seen challenges associated with the availability of staffing and increasing acuity of individuals. The system will seek to develop and reinforce the reablement offer to enable people to remain at home following discharge.

In the approach to estimating demand, as Stockport has seen year on year increases in activity, the system has anticipated a 10% min roundup for Projected figures for 2023-2024. The rationale for the demand for Pathway 2-3 is that these figures will not see this level of increased demand as referrals will go through process for D2A stepdown and spot purchasing before referral is sent for a placement to be sourced. This should manage the demand for this type of provision as part of the D2A pathways locally.

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.

Enabling people to stay safe, well and at home for longer is a crucial priority of Stockport's One Health and Care Plan which aligns to our Home First Ethos.

We will work together as ONE System to develop the way we deliver Adult Social Care and Health to help the people of Stockport to live their best lives possible. We will continue to develop and embed our operating models which promote prevention, reablement and a Home First ethos.

Our system has developed a new approach to intermediate care, based on:
- Prevention: helping people stay well so that they do not need formal care.
- Reablement: when people do need support, helping them recover and regain their independence whilst remaining in their own home.
- A Home First approach – delivering the right care and support to people within their own homes.
- Developing and implementing a strength and asset-based approach to enable people to utilise local and personal resources and support as much as possible without necessarily relying on formally provided and charged for services.
- Working with people who receive formal services to routinely review their care and support needs and ensure that any services they receive remain relevant and appropriate to theirs and their carer's circumstances.

This also applies to health services - when you are really sick, hospitals are the place you need to be. Ideally, services will prevent problems emerging in the first place, but when you do need help, it does not always need to be given in hospital. In Stockport we are committed to the following priorities and principles for the Home First Ethos:

- If you do need hospital treatment, this should be only for as long as necessary and your discharge should not be delayed. Once you are medically stable, you recover much better and faster at home with the right support around you. Being in familiar surroundings with support from loved ones, family and friends is also one of the best things for your mental wellbeing.
- We want to change the way we deliver care so that people in Stockport are supported to stay well and independent, to take charge of their own health and wellbeing, accessing support as close to home as possible.
- We will work closely with planning teams in the implementation of the 'Local Plan' to ensure that planning for housing and land use supports improved health, wellbeing and independence.
- We want services to create the conditions that enable people to live healthy and happy lives and offer proactive support when needed. This means working with people rather than doing things for or to them and helping people to access and develop the resources available to them. However, when people do need formal care and support our aim is wherever possible to take a re-abling approach and work to promote people's abilities and independence.

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.

Providing the right care in the right place at the right time is central to Stockport's Home First ambition. We are integrating care around neighbourhoods to support people to receive care when and where they need it. This is being done in partnership between NHS GM, SMBC and Stockport NHS Foundation Trust as well as primary care sector colleagues. Specific actions on this, mentioned throughout this narrative submission, are as follows:

<u>Ongoing arrangements to embed a home first approach:</u>
- Increased home care offer that will link into the proposed new Neighbourhood Model. Additional services that are dedicated to ensure that people are able to maintain their independence within their own home, avoiding the need for higher levels of care.

- Streamlining our services that wrap-around residential bed-based care in the community. This includes therapists, community nurses and social workers for example. Currently these teams deliver care across seven different sites and further integration across partners to fit in with neighbourhood boundaries will support a more flexible and consistent approach for individuals.

- Team Around the Practice builds on Primary Care Networks (PCNs) that have existed in Stockport for some time. The Team Around the Practice will bring together people working in physical health, mental health, voluntary services and social care. They are teams who work with General Practices, your local doctor's surgery, within a small defined area (your neighbourhood) to provide more local opportunities for you to access care without require higher levels of care. The Team Around the Practice will provide proactive and integrated care to local communities which keeps people well. People will not be referred between different services and as such their care journey will be seamless

- Integrated pathways of care where partners work collaboratively with a person-centred approach for the needs of the individual. Integrated Care Pathways define the expected course of events in the care of a patient with a particular condition within a set timescale where various different services combine together provide people with long-term conditions coordinated and simple access to care as close to home as

possible without having to be referred to various different places. Services have worked collaboratively in the past, but more integrated pathways will allow for them to work together more effectively as part of a larger community of organisations reaching across numerous services.

- We will deliver better health, better homes and better neighbourhoods for our population. We will harness our district centres and work to deliver future 'Model Urban' Neighbourhoods. This will deliver more homes for Stockport which are affordable and match housing needs. There will also be significant action taken against rogue landlords as well as the utilisation of empty housing.

Using additional funding to support discharge and free up beds: Stockport has continued to set challenging targets to reduce permanent admissions to residential care whilst below the regional and national averages this is an area of continued focus. A focus of the use of additional discharge funding is to review and further develop the reablement offer for individuals to remain at home following discharge to manage increasing levels of acuity of needs of individuals whilst ensuring sufficiency of bed based provision to free up hospital beds and promote flow out of hospital.

Tackling pressures in delayed discharges
- Delivery of the new Transfer of Care Hub, based at Stepping Hill Hospital, a new team that will work collaboratively with staff and patients alike to proactively return people to their usual place of residence.
- Delivery of the St Thomas' Gardens development which will see the transformation of the former hospital site into a 82 bed care facility. The vision for this development is locally based, services with a focus on helping primarily older people and people in need regain their independence and wherever possible a return home following discharge from hospital.

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.

As part of the system wide BCF review, taking into account the predictions and outturn from 2022/23, the workshop discussions centred on how a shift to reinforce home-based service options for people coming out of hospital could be implemented. This would require, primarily:

Additional workforce competency skills and availability across the health & social care economy

- Cultural shift around assessment to manage risks effectively in a home environment
- Housing related support including technology enabled care, review of our DFG approach and wider commitment to prevention.

The wider system impact of Stockport's relatively high spend against bed-based support has resulted in decisions to continue to commission additional community beds greater than current BCF funding. Whilst no specific instances of a person being offered support in a less appropriate service or pathway, the figures suggest that there is scope for a greater use of pathway 1 options. We are continuing to focus on maximising individual independence at all times and embed and develop our home first approach. We are anticipating an increase in discharges through 2023/24 and are keen to address the additional challenge through our home first ethos, investing in support for people to return to their own homes wherever possible, with an appropriate service and level of support in place.

The anticipated figures reflect this change in approach and there are challenges in ensuring that there is sufficient capacity to meet demand for people returning to their own home from hospital with support anticipate for the coming winter months. In mitigation there is significant work taking place around recruitment and investment in technology enabled care seeking to develop additional capacity to meet this

challenge.

There are some challenges in effectively managing demand for social support for people coming out of hospital in the Stockport system via pathway 0 in the short term. It is anticipated that this will be remedied with additional capacity being in place to meet these demands as seasonal pressures develop in the autumn. Reviewing the performance for the last year and in looking forward to 2023/24 we are anticipating that there will be sufficient bed based capacity to meet demand for people under pathways 2 and 3.

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

Stockport is embarking on an ambitious programme of transformation of our intermediate services, with a strong emphasis. This ambition centres upon using available BCF Funds for the delivery of a new, consolidated Intermediate Care Model that will cater for both Step Up and Step Down; reducing the need for NEL admission.

We will work together as ONE System to develop the way we deliver Health and Care to help the people of Stockport to live their best lives possible. We will continue to develop and embed our operating models which promote prevention, reablement and a Home First ethos. People will get the right care, in the right place at right time as close to hope as possible to maintain their independence and avoid higher levels of care.

Crucially, it is expected that individuals who need some combination of intermediate care and support to remain at home will be the primary beneficiaries of our plans.

- Delivery of the new Transfer of Care Hub, based at Stepping Hill Hospital, a new team that will work collaboratively with staff and patients alike to proactively return people to their usual place of residence.
- Streamlining our services that wrap-around residential bed-based care in the community. This includes therapists, community nurses and social workers for example. Currently these teams deliver care across seven different sites, it is proposed that this is reduced to two.
- Delivery of the St Thomas' Gardens development which will see the transformation of the former hospital site into a 82-bed care facility. The vision for this development is locally based, services with a focus on helping primarily older people and people in need regain their independence and wherever possible a return home.
- Increased home care offer that will link in to the proposed new Neighbourhood Model. Additional services that are dedicated to ensuring that people are able to maintain their independence within their own home, avoiding the need for higher levels of care.
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National Condition 3 (cont)

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

We have carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and have agreed actions for improving future performance which are reflected in our plan.

We have an aligned action against each of the eight system changes as outlined in the HICM:

System Change	Stockport Action	RAG
Early Discharge Planning	After having completed a gap analysis it is recognised that this is an area for improvement for us amongst some of our services and work is underway to mitigate this.	
Systems to monitor patient flow	Three times weekly whole-system Tactical meeting to discuss cross-system patient flow	
Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector	We have an MDT of NHS and Adult Social Care colleagues supporting discharge. This is combined with the Enhanced Hospital Discharge scheme which is led by Age UK Stockport.	
Home first/discharge to assess	The Home First Ethos is a key part of our One Health and Care Plan and the foundations upon which we build our D2A services in Stockport.	
Seven-day Services	After having completed a gap analysis it is recognised that this is a gap for us amongst some of our services and work is underway to mitigate this.	
Trusted Assessors	After having completed a gap analysis it is recognised that this is a gap for us amongst some of our services and work is underway to mitigate this.	

Focus on choice	After having completed a gap analysis it is recognised that this is a gap for us amongst some of our services and work is underway to mitigate this.	
Enhancing Health in Care Homes	EHCH is a key part of the Stockport Care Homes Improvement Plan with significant investment.	

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?

Our main priorities this past year have focused on the use of the relevant elements of BCF funding to address a range of activities. In particular,

- Supporting the integration of person-centred neighbourhood teams, supporting our most vulnerable with enhanced care plans
- Ensuring we maintain our 'Home First' ethos supporting our patients to remain independent and ensuring patients get the right care, in the right place, at the right time
    - Additional services in the community to avoid attendances and admissions, including the digitisation of care
    - Discharging patients as safely and effectively as possible, through early supported discharge and the enhancement of our wider Discharge to Assess model
- In line with our Locality plan, the reduction of health inequalities and increased focus on population health

Our main priorities this past year have focused on the use of the relevant elements of BCF funding to address a range of activities. In particular,

- Supporting the integration of person-centred neighbourhood teams, supporting our most vulnerable with enhanced care plans
- Ensuring we maintain our 'Home First' ethos supporting our patients to remain independent and ensuring patients get the right care, in the right place, at the right time
    - Additional services in the community to avoid attendances and admissions, including the digitisation of care
    - Discharging patients as safely and effectively as possible, through early supported discharge and the enhancement of our wider Discharge to Assess model
- In line with our Locality plan, the reduction of health inequalities and increased focus on population health

A system wide BCF review was completed with outcomes presented to representatives of the System Executive Leadership in March 2023. National Better Care Fund specialist resource accessed through the LGA Care and Health Improvement programme has been secured to support this review.

The Council's direct discharge allocation in 2022/23 was £1.069m. The Greater Manchester (GM) ICB received a total allocation in 2022/23 of £19.558m covering the Greater Manchester region. The allocation to Stockport was £1.873m. Locality health and social care partners had committed significant expenditure to support Discharge to Assess capacity, with proposals to use most of the £1.873m allocation to continue this activity in line with the conditions of the grant.

Through the Urgent Care Delivery Board (UCDB) agreed costed schemes had been submitted to GM ICB. This was a requirement of the GM ICB and was done prior to the announcement on the specific monies available and their associated conditions.

The table below illustrates the actual expenditure at 2022/23 outturn for the funding the locality received for hospital discharge services. This aligned to the 2022/23 BCF outturn report submission for the ASC Discharge Fund. The schemes aligned to the formal grant conditions to support the health and care system in Stockport. They were based on national best practice, alongside supporting local key risks and where it might be possible to deliver sustainable longer-term change.

The schemes included already committed expenditure to support discharge to both homebased and bed based provision.

Scheme Type	**Detail**	**Outturn**
Reablement in a Person's Own Home	Support into reablement services through recruitment of agency staff to support staffing levels.	£0.100m
Additional or redeployed capacity from current care workers	Additional Social Work capacity to support patient flow out of hospital alongside extended working/weekend discharge	£0.183m
Home Care or Domiciliary Care	Additional Brokerage/ Commissioning capacity and market incentives to support out of hours and weekend working to support discharges 7 days a week	£0.011m
Additional Pathway 1 Capacity	Additional hours of commissioned services to support Pathway 1 discharges into a person's own home	£0.704m
Additional Pathway 2 Capacity	Additional bed based provision to support discharge to assess pathways into a residential care home	£1.944m
	Total	**£2.942m**

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.

According to the 2021 Census data, Stockport has a population of 294,800 people, many of whom have significant caring responsibilities. A summary of the census data confirms the following:

- 5% of Stockport residents (aged 5 years and over) reported providing 19 hours of unpaid care per week
- 1 in 50 people (1.8%) reported providing between 20 and 49 hours of unpaid care per week
- 2.7% of Stockport residents (aged 5 years and over) provide at least 50 hours of unpaid weekly care[1]

The main provision for carers is commissioned by Adult Social Care, with Signpost Stockport and Stockport Mind delivering a range of support options as part of this contract. The contract value is 200K, which includes 50K from the Better Care Fund. This funding provides a 'one stop shop' for carers, which includes independent Carers Assessments and Reviews; signposting to appropriate support services, information advice and guidance, welfare benefits support and a range of groups and activities to provide carers with a break and opportunities to spend time with other carers, to share experiences and enable peer support.

During 22/23 Signpost and Stockport Mind received 457 requests for new Carers Assessments and a total of 606 new Carers Assessments and reviews were completed during the year. Demand for Carers Assessments has increased over the last year and this challenge has resulted in the providers implementing new ways of working. This has included options for carers to complete an online review form, which has been piloted successfully and is now being fully implemented. The option for an online initial Carers Assessment is also currently being piloted. Following assessments and reviews, carers are invited to apply for an annual 'thank you' payment of £200, which is funded by the Better Care Fund.

As part of the new online assessment forms, a question is asked in relation to how carers are feeling, with a choice of 46 words. During the period January – March '23, 73 carers responded to this question as follows:

• 67% are tired	• 44% are anxious
• 56% are stressed	• 34% are pressured
• 37% are coping	• 1% feel resourceful
• 36% felt needed	• 1% feel stimulated
• 33% felt depressed	• 0% feel rested

We know that unpaid carers face significant challenges on a daily basis and this feedback reflects this. We are committed to understanding the needs of carers in Stockport more fully and to this end, the development of a Carers Strategy is one of our key priorities for Qtr 2. We will also be working with Signpost and Stockport Mind to develop a Carers Partnership Board and aim to have this up and running by the start of Qtr 3. A review of respite options funded by the Better Care Fund is also underway, to ensure that sufficient respite options are available to people with care and support needs and their carers.

The initiatives described above will place the voice of carers at the front and centre of the work and we are committed to reviewing and developing our current and future support offers in partnership with carers. We

[1] How life has changed in Stockport: Census 2021 (ons.gov.uk)

are also committed to ensuring that carers from all sections of the community, including communities of identity, are aware of and engaging with this work to ensure that their voices are heard and their needs understood.

Disabled Facilities Grant (DFG) and wider services

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

Funding for the Disabilities Facilities Grant is paid to Stockport Metropolitan Borough Council through a section 31 grant. c£3m is deployed through the Better Care Fund for the provision of equipment and home adaptations to support independent living. There is also a significant investment of £500k to a fleet of apartments on Stockport Road. These apartments are to support Stockport residents with disabilities to live independently, in a small group or alone with an appropriate level of support in the community.

Most DFGs are delivered through the Council's Home Improvement Agency (HIA) which is operated by Stockport Homes. All works are organised and delivered directly by the HIA on behalf of the client, rather than the family having to arrange the works. This ensures works are undertaken correctly & professionally with all associated warranties.

Disabled Facilities Grants are provided to facilitate the provision of major adaptations or changes to non-council owned housing (i.e. owner occupied, private rented and housing association) to meet the assessed needs of disabled people of all ages.

Provision is demand-led. Offers of grant are based on the outcome of an assessment of need and are mandatory, subject to a grant applicant meeting the eligibility criteria, which for disabled adults includes a financial means test.

Typical examples of adaptations funded by a DFG include stairlifts, hoists, level access showers, door widening and ramps.

Customer confidence has returned following the Covid-19 pandemic and demand has returned to pre Covid-19 levels.

DFG expenditure at 2022/23 outturn included commitments against mandatory DFG provision alongside in year capitalisation of ASC expenditure aligned to equipment purchases. Balances were aligned to support the investment into the local Care Academy development.

As part of our review of current BCF DFG investment a priority for 2023/24 will be exploring our approach to expanding the use of assistive technologies.

Additional information (not assured)

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

We have not made use of the RRO provision as related to Housing Assistance.

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

Click or tap here to enter text.

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.

It is an essential priority of the One Stockport Health and Care Board to significantly reduce health inequalities. Stockport is one of the most polarized boroughs in the country, with some of the most affluent and some of the most deprived local areas, generating significant inequalities among community groups. 17.4% of our population live in the most deprived wards whilst 25.6% live in the most affluent wards.

Stockport has the oldest age profile in Greater Manchester and the population continues to age. Currently 20.2% of people are aged 65+ and this is likely to rise to 21.8% by 2028.

In Stockport the Black, Asian & ethnic minority population has risen from 11% in 2011 to around 17% at the 2021 census. Areas to the west of the borough have the highest proportion of ethnic diversity - particularly among younger populations.

40% of people registered with a Stockport GP have one or more long-term health conditions and around 26,200 people reported providing unpaid care to a friend or relative at the 2021 Census, including 420 children aged under 16. 7,560 local children have special educational needs and / or a disability. Over 2,000 children are classed as ‘in need’ with 490 Looked After Children and 243 care leavers 18-25yrs.
In the development of the One Stockport Health and Care Plan we undertook significant engagement with our local population. Some common themes emerged from these exercises around equality and health inequalities and are outlined below.

- Local people expressed concerns about widening health inequalities, exaggerated by the impacts of COVID, and asked us to focus on this as a priority.
- There was a strong message that a one-size-fits-all approach is not suitable for everyone and we need to consider wider sectors of our communities. Engagement highlighted that cultural competency is important for services
- Respondents highlighted steps they could take to help address inequalities and these focused around self-care, but there were recurrent barriers such as people not knowing where to get support or issues around time.

In order to take effective action against health inequalities and to ensure that we are addressing the concerns outlined above the Stockport population we will undertake the following actions:

- We will work together as ONE system to develop and deliver an all-age mental health and wellbeing strategy with a focus on improving the mental wellbeing of our residents and improving the access of services for all.
- We will work together as ONE System to be a Child-Friendly Borough through delivery of our Start Well Strategy, Children & Young People's Plan and our SEND Strategy and Joint Commissioning Plan. We will proactively support children and their families to have the best outcomes in life and prepare well for adulthood, with a strong focus on deprived areas.
- Our central ambitions, in respect of Elective Care and Cancer, are focused on improving waiting list times for elective care, improving access, streamlining process, eliminating duplication and ensuring that people on elective and suspected cancer pathways get the right care, in the right place at the right time.
- We will work together as ONE System through a new neighbourhood model that recognises wider determinant factors such as education, housing, employment, and social connectedness and how they interlink with the health of our population. We our redirecting funds from our more affluent areas to our more deprived areas to take action on this.
- The only way to improve health and care for everyone in Stockport is to work together as ONE system, wrapping care around the needs of the family and or individual. We will work together to create a sustainable, person-centred system where professionals work together with local communities to prevent ill health, proactively support people to remain independent and offer high quality care when needed. Wrapping care around the needs of the individual starts in primary care, the 'front door' of the NHS.

We will work together as ONE System to develop the way we deliver Adult Social Care and Health to help the people of Stockport to live their best lives possible. We will continue to develop and embed our operating models which promote prevention, reablement and a Home First ethos.