# BCF Planning Template 2023-25

**1. Guidance**

## Overview

**Note on entering information into this template**

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

### 2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

### 4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

### 5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

## 6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.
12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

## 7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

**8. Planning Requirements**

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

# Better Care Fund 2023-25 Template

**2. Cover**

**Version 1.1.3**

*Please Note:*

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

| | |
|---|---|
| **Health and Wellbeing Board:** | Barking and Dagenham |
| **Completed by:** | Louise Hider-Davies |
| **E-mail:** | louise.hiderdavies@lbbd.gov.uk |
| **Contact number:** | 020 8057 5553 |
| **Has this report been signed off by (or on behalf of) the HWB at the time of submission?** | Yes |
| **If no please indicate when the HWB is expected to sign off the plan:** | |

| | Role: | Professional Title (e.g. Dr, Cllr, Prof) | First-name: | Surname: | E-mail: |
|---|---|---|---|---|---|
| ***Area Assurance Contact Details:** | Health and Wellbeing Board Chair | Cllr | Maureen | Worby | maureen.worby@lbbd.gov.uk |
| | Integrated Care Board Chief Executive or person to whom they have delegated sign-off | | Charlotte | Pommery | charlotte.pomery@nhs.net |
| | Additional ICB(s) contacts if relevant | | Sharon | Morrow | sharon.morrow2@nhs.net |
| | Local Authority Chief Executive | | Fiona | Taylor | fiona.taylor@lbbd.gov.uk |
| | Local Authority Director of Adult Social Services (or equivalent) | | Elaine | Allegretti | elaine.allegretti@lbbd.gov.uk |
| | Better Care Fund Lead Official | | Louise | Hider-Davies | louise.hiderdavies@lbbd.gov.uk |
| | LA Section 151 Officer | | Philip | Gregory | philip.gregory@lbbd.gov.uk |
| *Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process --> | | | | | |
| | | | | | |
| | | | | | |

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

**Please see the Checklist below for further details on incomplete fields**

| | Complete: |
|---|---|
| 2. Cover | Yes |
| 4. Capacity&Demand | Yes |
| 5. Income | Yes |
| 6a. Expenditure | No |
| 7. Metrics | No |
| 8. Planning Requirements | Yes |


<< Link to the Guidance sheet

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# Better Care Fund 2023-25 Template

**3. Summary**

Selected Health and Wellbeing Board: Barking and Dagenham

## Income & Expenditure

Income >>

| Funding Sources | Income Yr 1 | Income Yr 2 | Expenditure Yr 1 | Expenditure Yr 2 | Difference |
|---|---|---|---|---|---|
| DFG | £1,856,901 | £1,856,901 | £1,856,901 | £1,856,901 | £0 |
| Minimum NHS Contribution | £18,440,057 | £19,483,764 | £18,440,057 | £19,483,764 | £0 |
| iBCF | £10,707,003 | £10,707,003 | £10,707,003 | £10,707,003 | £0 |
| Additional LA Contribution | £0 | £0 | £0 | £0 | £0 |
| Additional ICB Contribution | £295,000 | £0 | £295,000 | £0 | £0 |
| Local Authority Discharge Funding | £1,501,105 | £2,491,834 | £1,501,105 | £2,491,834 | £0 |
| ICB Discharge Funding | £890,553 | £890,553 | £890,553 | £890,553 | £0 |
| **Total** | **£33,690,619** | **£35,430,055** | **£33,690,619** | **£35,430,055** | **£0** |

Expenditure >>

**NHS Commissioned Out of Hospital spend from the minimum ICB allocation**

| | Yr 1 | Yr 2 |
|---|---|---|
| Minimum required spend | £5,240,141 | £5,536,733 |
| Planned spend | £11,025,194 | £11,658,281 |

**Adult Social Care services spend from the minimum ICB allocations**

| | Yr 1 | Yr 2 |
|---|---|---|
| Minimum required spend | £6,832,572 | £7,219,296 |
| Planned spend | £7,414,862 | £7,825,483 |

Metrics >>

## Avoidable admissions

| | 2023-24 Q1 Plan | 2023-24 Q2 Plan | 2023-24 Q3 Plan | 2023-24 Q4 Plan |
|---|---|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population) | 181.2 | 180.5 | 173.2 | 156.5 |

## Falls

| 2022-23 estimated | 2023-24 Plan |
|---|---|

| | | | |
|---|---|---|---|
| Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | Indicator value | 0.0 | 0.0 |
| | Count | 0 | 0 |
| | Population | 0 | 0 |

## Discharge to normal place of residence

| | 2023-24 Q1 Plan | 2023-24 Q2 Plan | 2023-24 Q3 Plan | 2023-24 Q4 Plan |
|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | | | | |

## Residential Admissions

| | | 2021-22 Actual | 2023-24 Plan |
|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual Rate | 651 | 708 |

## Reablement

| | | 2023-24 Plan |
|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 84.1% |

Planning Requirements >>

| Theme | Code | Response |
|---|---|---|
| **NC1: Jointly agreed plan** | **PR1** | Yes |
| | **PR2** | Yes |
| | **PR3** | Yes |
| **NC2: Social Care Maintenance** | **PR4** | Yes |

| | | |
|---|---|---|
| **NC3: NHS commissioned Out of Hospital Services** | **PR5** | Yes |
| **NC4: Implementing the BCF policy objectives** | **PR6** | Yes |
| **Agreed expenditure plan for all elements of the BCF** | **PR7** | Yes |
| **Metrics** | **PR8** | Yes |

# Better Care Fund 2023-24 Capacity & Demand Template

**3. Capacity & Demand**

Selected Health and Wellbeing Board: Barking and Dagenham

**Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements**

**3.1 Demand - Hospital Discharge**

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

**3.2 Demand - Community**

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

**3.3 Capacity - Hospital Discharge**

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

**3.4 Capacity - Community**

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

| **Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.** | Reablement demand projections relate to short-term crisis packages. The demand forecast is based on historic data, using linear regression. Homecare service data has been excluded from projected totals. There are no waiting lists for short term services. Length of stay is expected to remain stable into 2023-24. Activity levels were higher than forecast figures from the 2022-23 capacity and demand planning. The level of demand in 2023-24 is expected to be similar to the previous year. The integrated system is flexible in response to referrals and capacity is able to meet demand, therefore these figures are aligned. |
|---|---|

| | **Complete:** |
|---|---|
| **3.1** | Yes |
| **3.2** | Yes |
| **3.3** | Yes |
| **3.4** | Yes |

**3.1 Demand - Hospital Discharge**

!!Click on the filter box below to select Trust first!!

| Trust Referral Source (Select as many as you need) | Demand - Hospital Discharge Pathway | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (Please select Trust/s.....) | Social support (including VCS) (pathway 0) | | | | | | | | | | | | |
| BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST | | 36 | 39 | 41 | 43 | 45 | 47 | 50 | 52 | 54 | 56 | 59 | 61 |
| (Please select Trust/s.....) | Reablement at home (pathway 1) | | | | | | | | | | | | |
| BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST | | 64 | 64 | 64 | 64 | 64 | 64 | 67 | 67 | 67 | 67 | 67 | 67 |
| (Please select Trust/s.....) | Rehabilitation at home (pathway 1) | | | | | | | | | | | | |
| BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST | | 19.5 | 21 | 20 | 19.5 | 20 | 10 | 11.7 | 11.7 | 13 | 21 | 18 | 18 |
| (Please select Trust/s.....) | Short term domiciliary care (pathway 1) | | | | | | | | | | | | |
| BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST | | | | | | | | | | | | | |
| (Please select Trust/s.....) | Reablement in a bedded setting (pathway 2) | | | | | | | | | | | | |
| BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST | | | | | | | | | | | | | |
| (Please select Trust/s.....) | Rehabilitation in a bedded setting (pathway 2) | | | | | | | | | | | | |
| BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST | | 15 | 14 | 14 | 14 | 14 | 14 | 14 | 15 | 15 | 15 | 15 | 15 |
| (Please select Trust/s.....) | Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | | | | | | | | | | | | |
| BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST | | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **Totals** | **Total:** | 137.5 | 141 | 142 | 143.5 | 146 | 138 | 145.7 | 148.7 | 152 | 162 | 162 | 164 |

**3.2 Demand - Community**

| Demand - Intermediate Care Service Type | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |
| Urgent Community Response | 201 | 184 | 176 | 193 | 179 | 145 | 157 | 162 | 154 | 117 | 123 | 160 |
| Reablement at home | 36 | 36 | 37 | 37 | 37 | 37 | 38 | 38 | 39 | 39 | 40 | 40 |
| Rehabilitation at home | 10.5 | 11.3 | 11 | 10.5 | 11 | 5.2 | 6.3 | 6.3 | 7 | 11.5 | 9.7 | 9.7 |
| Reablement in a bedded setting | | | | | | | | | | | | |
| Rehabilitation in a bedded setting | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Other short-term social care | | | | | | | | | | | | |

**3.3 Capacity - Hospital Discharge**

| Capacity - Hospital Discharge Service Area | Metric | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB | LA | Joint |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | Monthly capacity. Number of new clients. | 36 | 39 | 41 | 43 | 45 | 47 | 50 | 52 | 54 | 56 | 59 | 61 | | 100% | |
| Reablement at Home | Monthly capacity. Number of new clients. | 64 | 64 | 64 | 64 | 64 | 64 | 67 | 67 | 67 | 67 | 67 | 67 | | 100% | |
| Rehabilitation at home | Monthly capacity. Number of new clients. | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 12.7 | 100% | | |
| Short term domiciliary care | Monthly capacity. Number of new clients. | | | | | | | | | | | | | | | |
| Reablement in a bedded setting | Monthly capacity. Number of new clients. | | | | | | | | | | | | | | | |
| Rehabilitation in a bedded setting | Monthly capacity. Number of new clients. | 16 | 15 | 15 | 15 | 15 | 15 | 15 | 16 | 16 | 16 | 16 | 16 | 100% | | |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement | Monthly capacity. Number of new clients. | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | | 100% | |

**3.4 Capacity - Community**

| Capacity - Community Service Area | Metric | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB | LA | Joint |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | Monthly capacity. Number of new clients. | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 | | 100% | |
| Urgent Community Response | Monthly capacity. Number of new clients. | 187 | 158 | 153 | 157 | 147 | 132 | 130 | 124 | 102 | 96 | 99 | 129 | 100% | | |
| Reablement at Home | Monthly capacity. Number of new clients. | 36 | 36 | 37 | 37 | 37 | 37 | 38 | 38 | 39 | 39 | 40 | 40 | | 100% | |
| Rehabilitation at home | Monthly capacity. Number of new clients. | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 6.9 | 100% | | |
| Reablement in a bedded setting | Monthly capacity. Number of new clients. | | | | | | | | | | | | | | | |
| Rehabilitation in a bedded setting | Monthly capacity. Number of new clients. | 1.1 | 1 | 1 | 1 | 1 | 1 | 1 | 1.1 | 1.1 | 1.1 | 1.1 | 1.1 | 100% | | |
| Other short-term social care | Monthly capacity. Number of new clients. | | | | | | | | | | | | | | | |

# Better Care Fund 2023-25 Template

**4. Income**

Selected Health and Wellbeing Board: Barking and Dagenham

| **Local Authority Contribution** | | |
|---|---|---|
| Disabled Facilities Grant (DFG) | Gross Contribution Yr 1 | Gross Contribution Yr 2 |
| Barking and Dagenham | £1,856,901 | £1,856,901 |
| | | |
| DFG breakdown for two-tier areas only (where applicable) | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Total Minimum LA Contribution (exc iBCF)** | **£1,856,901** | **£1,856,901** |

| **Local Authority Discharge Funding** | Contribution Yr 1 | Contribution Yr 2 |
|---|---|---|
| Barking and Dagenham | £1,501,105 | £2,491,834 |

| **ICB Discharge Funding** | Contribution Yr 1 | Contribution Yr 2 |
|---|---|---|
| NHS North East London ICB | £890,553 | £890,553 |
| | | |
| | | |
| **Total ICB Discharge Fund Contribution** | £890,553 | £890,553 |

| **iBCF Contribution** | Contribution Yr 1 | Contribution Yr 2 |
|---|---|---|
| Barking and Dagenham | £10,707,003 | £10,707,003 |
| | | |
| **Total iBCF Contribution** | **£10,707,003** | **£10,707,003** |

| Are any additional LA Contributions being made in 2023-25? If yes, please detail below | No |
|---|---|

| Local Authority Additional Contribution | Contribution Yr 1 | Contribution Yr 2 | Comments - Please use this box to clarify any specific uses or sources of funding |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Total Additional Local Authority Contribution** | **£0** | **£0** | |

| NHS Minimum Contribution | Contribution Yr 1 | Contribution Yr 2 |
|---|---|---|
| NHS North East London ICB | £18,440,057 | £19,483,764 |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Total NHS Minimum Contribution** | **£18,440,057** | **£19,483,764** |

| | |
|---|---|
| Are any additional ICB Contributions being made in 2023-25? If yes, please detail below | Yes |

| Additional ICB Contribution | Contribution Yr 1 | Contribution Yr 2 | Comments - Please use this box clarify any specific uses or sources of funding |
|---|---|---|---|
| NHS North East London ICB | £295,000 | | Ageing Well contribution |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Total Additional NHS Contribution** | **£295,000** | **£0** | |
| **Total NHS Contribution** | **£18,735,057** | **£19,483,764** | |

| | 2023-24 | 2024-25 |
|---|---|---|
| **Total BCF Pooled Budget** | **£33,690,619** | **£35,430,055** |

| **Funding Contributions Comments** |
|---|
| Optional for any useful detail e.g. Carry over |
| |

**See next sheet for Scheme Type (and Sub Type) descriptions**

# Better Care Fund 2023-25 Template

**5. Expenditure**

Selected Health and Wellbeing Board: Barking and Dagenham

<< Link to summary sheet

| Running Balances | 2023-24 Income | 2023-24 Expenditure | 2023-24 Balance | 2024-25 Income | 2024-25 Expenditure | 2024-25 Balance |
|---|---|---|---|---|---|---|
| DFG | £1,856,901 | £1,856,901 | £0 | £1,856,901 | £1,856,901 | £0 |
| Minimum NHS Contribution | £18,440,057 | £18,440,057 | £0 | £19,483,764 | £19,483,764 | £0 |
| IBCF | £10,707,003 | £10,707,003 | £0 | £10,707,003 | £10,707,003 | £0 |
| Additional LA Contribution | £0 | £0 | £0 | £0 | £0 | £0 |
| Additional NHS Contribution | £295,000 | £295,000 | £0 | £0 | £0 | £0 |
| Local Authority Discharge Funding | £1,501,105 | £1,501,105 | £0 | £2,491,834 | £2,491,834 | £0 |
| ICB Discharge Funding | £890,553 | £890,553 | | £890,553 | £890,553 | £0 |
| **Total** | **£33,690,619** | **£33,690,619** | **£0** | **£35,430,055** | **£35,430,055** | **£0** |

**Required Spend**

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

| | 2023-24 Minimum Required Spend | 2023-24 Planned Spend | 2023-24 Under Spend | 2024-25 Minimum Required Spend | 2024-25 Planned Spend | 2024-25 Under Spend |
|---|---|---|---|---|---|---|
| NHS Commissioned Out of Hospital spend from the minimum ICB allocation | £5,240,141 | £11,025,194 | £0 | £5,536,733 | £11,658,281 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £6,832,572 | £7,414,862 | £0 | £7,219,296 | £7,825,483 | £0 |

**Checklist**

Column complete:

| Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**>> Incomplete fields on row number(s):**

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110

| | | | | | | | | | Planned Expenditure | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Please specify if 'Scheme Type' is 'Other' | Expected outputs 2023-24 | Expected outputs 2024-25 | Units | Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
| 1 | Targeted out of hospital care | Integrated case management delivered through cluster multi disciplinary staff teams | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £2,136,902 | £2,547,523 | 100% |
| 2 | Hospital discharge, planning and | Services and support to ensure timely discharge from hospital and admission | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £847,610 | £847,610 | 100% |
| 3 | Targeted out of hospital care | Crisis Intervention/ Reablement/Homecare | Home-based intermediate care services | Reablement at home (to support discharge) | | 700 | 700 | Packages | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £1,332,133 | £1,332,133 | 100% |
| 4 | Community support and independence | Care Bill Implementation to support prevention, integration, independence | Care Act Implementation Related Duties | Other | Care Act fee increases and safeguarding | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £657,607 | £657,607 | 100% |
| 5 | Hospital discharge, planning and | Home is best | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £24,000 | £24,000 | 100% |
| 6 | Targeted out of hospital care | Supporting adults of working age with mental health problems to live | Personalised Care at Home | Mental health /wellbeing | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £572,000 | £572,000 | 100% |
| 7 | Targeted out of hospital care | Resource and systems to support integration, better processes and provider | Enablers for Integration | Data Integration | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £26,000 | £26,000 | 100% |
| 8 | Community support and independence | Care Bill Implementation to support prevention, integration, independence | Care Act Implementation Related Duties | Other | Safeguarding Adults | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £130,000 | £130,000 | 100% |
| 9 | Hospital discharge, planning and | Care Home Trusted Assessors | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £8,500 | £8,500 | 100% |
| 10 | Community support and independence | Preventative services to prevent falls and promote health & wellbeing | Prevention / Early Intervention | Risk Stratification | | | | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £50,000 | £50,000 | 100% |
| 11 | Community support and independence | Care technology, equipment and adaptations | Assistive Technologies and Equipment | Community Based Equipment | | 250 | 250 | Number of beneficiaries | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £80,000 | £80,000 | 100% |
| 12 | Community support and independence | Care Bill Implementation to support prevention, integration, independence | Care Act Implementation Related Duties | Other | Social Isolation Pilot | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £100,000 | £100,000 | 100% |
| 13 | Targeted out of hospital care | Developing joint commissioning to achieve the outcomes of the BCF for | Residential Placements | Care home | | 20 | 20 | Number of beds/Placements | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £947,610 | £947,610 | 100% |
| 14 | Community support and independence | Support for the Personal Assistant market | Personalised Budgeting and Commissioning | | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £150,000 | £150,000 | 100% |
| 15 | Community support and independence | Support for service users with dementia and their informal carers | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £100,000 | £100,000 | 100% |
| 16 | Community support and independence | Support for carer support organsitons. | Carers Services | Other | Support for carer support organsitons. | 950 | 950 | Beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £75,000 | £75,000 | 100% |
| 17 | Community support and independence | Strengthening User and Carer Voice | Carers Services | Other | Strengthening User and Carer Voice | 950 | 950 | Beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £62,500 | £62,500 | 100% |
| 18 | Provide the right care in the right place at the right | Home from Hospital - Home, Settle and Support Service (British Red Cross) on | Integrated Care Planning and Navigation | Other | Care Planning, Assessment and Review | | | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £65,000 | £65,000 | 100% |
| 19 | Community support and independence | Care technology, equipment and adaptations | Assistive Technologies and Equipment | Other | Care Planning, Assessment and Review | 156 | 156 | Number of beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £50,000 | £50,000 | 100% |
| 20 | Provide the right care in the right place at the right | Care - Coordination to support discharge | Community Based Schemes | Integrated neighbourhood services | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £6,632,116 | £7,029,113 | 100% |
| 21 | Enable people to stay well, safe and independent at | Various community based services | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £2,842,335 | £3,012,477 | 100% |
| 22 | Enable people to stay well, safe and independent at | Various community based services | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £56,422 | £59,616 | 100% |
| 23 | Enable people to stay well, safe and independent at | Various community based services | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £410,570 | £425,925 | 100% |
| 24 | Enable people to stay well, safe and independent at | Supported Employment | High Impact Change Model for Managing Transfer of Care | Other | Other approaches | | | | Mental Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £230,064 | £245,812 | 100% |
| 25 | Enable people to stay well, safe and independent at | CCG Contribution to the local carers organisation | Carers Services | Other | Carer Advice and Support | 950 | 950 | Beneficiaries | Community Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £12,253 | £12,638 | 100% |
| 26 | Enable people to stay well, safe and independent at | CCG Contribution to the local carers organisation | Carers Services | Other | Carer Advice and Support | 950 | 950 | Beneficiaries | Community Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £15,471 | £15,957 | 100% |
| 27 | Provide the right care in the right place at the right | Home from Hospital - Home, Settle and Support Service (British Red Cross) on | Integrated Care Planning and Navigation | Other | Care Planning, Assessment and Review | | | | Community Health | | NHS | | | Local Authority | Minimum NHS Contribution | Existing | £18,590 | £19,174 | 100% |
| 28 | Provide the right care in the right place at the right | Home First same & next day discharge - AHPs. | Home-based intermediate care services | Reablement at home (to support discharge) | | 520 | 520 | Packages | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £114,658 | £118,946 | 100% |
| 29 | Enable people to stary well, safe and independent | Urgent Care 2 Hour response (Ageing Well) | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £298,296 | £309,452 | 100% |
| 30 | Enable people to stary well, safe and independent | Urgent Care 2 Hour response (Ageing Well) | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £220,738 | £228,994 | 100% |
| 31 | Enable people to stary well, safe and independent | Urgent Care 2 Hour response (Ageing Well) | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS Community Provider | Additional NHS Contribution | Existing | £295,000 | £0 | 100% |
| 32 | Enable people to stay well, safe and independent at | Voluntary sector | Carers Services | Respite services | | 11 | 11 | Beneficiaries | Community Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £173,682 | £180,177 | 100% |
| 33 | Community support and independence | Supporting people to remain in their homes through the provision of adaptations | DFG Related Schemes | Adaptations, including statutory DFG grants | | 150 | 150 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG | Existing | £1,856,901 | £1,856,901 | 100% |
| 34 | Targeted out of hospital care | Crisis Intervention/ Reablement/Homecare | Home-based intermediate care services | Reablement at home (to support discharge) | | 300 | 300 | Packages | Social Care | | LA | | | Private Sector | iBCF | Existing | £500,000 | £500,000 | 100% |
| 35 | Targeted out of hospital care | Managing homecare and additonal demand over winter in particular within | Home Care or Domiciliary Care | Domiciliary care packages | | 45000 | 45000 | Hours of care | Social Care | | LA | | | Private Sector | iBCF | Existing | £913,062 | £913,062 | 100% |
| 36 | Targeted out of hospital care | Support to manage safeguarding of Adults and DoLS | Care Act Implementation Related Duties | Safeguarding | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £175,000 | £175,000 | 100% |
| 37 | Market Stabilisation & COVID Recovery | Market Development/Fee increases | Residential Placements | Other | Fee increase to stabilise the care provider market | 500 | 500 | Number of beds/Placements | Social Care | | LA | | | Private Sector | iBCF | Existing | £1,600,000 | £1,600,000 | 100% |
| 38 | Community support and independence | Care technology, equipment and adaptations | Assistive Technologies and Equipment | Assistive technologies including telecare | | 3000 | 3000 | Number of beneficiaries | Social Care | | LA | | | Private Sector | iBCF | Existing | £680,000 | £680,000 | 100% |
| 39 | Targeted out of hospital care | Additional Care Navigators, investment in Mental Health, transforming care held cases | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £1,514,420 | £1,514,420 | 100% |
| 40 | Targeted out of hospital care | Develop joint commissioning to achieve the outcomes of the BCF for local residents | Integrated Care Planning and Navigation | Assessment teams/joint assessment | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £2,980,000 | £2,980,000 | 100% |
| 41 | Targeted out of hospital care | Supporting adults of working age with mental health problems to live | Personalised Care at Home | Mental health /wellbeing | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £500,000 | £500,000 | 100% |
| 42 | Targeted out of hospital care | Supported Employment | Prevention / Early Intervention | Other | Supported employment approaches | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £100,000 | £100,000 | 100% |
| 43 | Targeted out of hospital care | Resource and systems to support integration, better processes and provider | Enablers for Integration | Data Integration | | | | | Social Care | | LA | | | Private Sector | iBCF | Existing | £100,000 | £100,000 | 100% |
| 44 | Community support and independence | LD Demand growth and Transitions | Residential Placements | Learning disability | | 6 | 6 | Number of beds/Placements | Social Care | | LA | | | Private Sector | iBCF | Existing | £1,484,521 | £1,484,521 | 100% |
| 45 | Community support and independence | LD Employment and NEETs | Prevention / Early Intervention | Other | Employment support | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £150,000 | £150,000 | 100% |
| 46 | Market Development /Fee increases | Home Care or Domiciliary Care | Workforce recruitment and retention | | | | | | Social Care | | LA | | | Private Sector | iBCF | Existing | £10,000 | £10,000 | 100% |
| 47 | Hospital discharge, planning and | Commissioning project management to support Discharge Fund initiatives | Enablers for Integration | Joint commissioning infrastructure | | | | | Social Care | | LA | | | Local Authority | Local Authority Discharge | New | £80,000 | £80,000 | 100% |
| 48 | Hospital discharge, planning and | Support for complex discharge cases | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Social Care | | LA | | | Local Authority | ICB Discharge Funding | New | £100,000 | £100,000 | 100% |
| 49 | Targeted out of hospital care | Unfunded homecare and crisis intervention packages (single and double handed) | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess | | 35000 | 35000 | Hours of care | Social Care | | LA | | | Private Sector | ICB Discharge Funding | New | £700,000 | £700,000 | 100% |
| 50 | Targeted out of hospital care | Unfunded residential, nursing and supported living placements | Residential Placements | Care home | | 18 | 18 | Number of beds/Placements | Social Care | | LA | | | Private Sector | Local Authority Discharge | New | £803,105 | £803,105 | 100% |
| 51 | Targeted out of hospital care | Unfunded reablement packages/reablement pilot | Home-based intermediate care services | Reablement at home (to support discharge) | | 100 | 100 | Packages | Social Care | | LA | | | NHS Community Provider | Local Authority Discharge | New | £618,000 | £618,000 | 100% |
| 52 | Hospital discharge, planning and | Workforce support | Workforce recruitment and retention | | | | | | Social Care | | LA | | | Local Authority | ICB Discharge Funding | New | £90,553 | £90,553 | 100% |
| 53 | Targeted out of hospital care | Unfunded packages and placements - to be determined for 24/25 | Residential Placements | Care home | | 23 | 23 | Number of beds/Placements | Social Care | | LA | | | Local Authority | Local Authority Discharge | New | £0 | £990,729 | 100% |

## Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

### 2023-25 Revised Scheme types

| Number | Scheme type/ services | Sub type | Description |
|---|---|---|---|
| 1 | Assistive Technologies and Equipment | 1. Assistive technologies including telecare<br>2. Digital participation services<br>3. Community based equipment<br>4. Other | Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services). |
| 2 | Care Act Implementation Related Duties | 1. Independent Mental Health Advocacy<br>2. Safeguarding<br>3. Other | Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF. |
| 3 | Carers Services | 1. Respite Services<br>2. Carer advice and support related to Care Act duties<br>3. Other | Supporting people to sustain their role as carers and reduce the likelihood of crisis.<br><br>This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. |
| 4 | Community Based Schemes | 1. Integrated neighbourhood services<br>2. Multidisciplinary teams that are supporting independence, such as anticipatory care<br>3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0)<br>4. Other | Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams)<br><br>Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home' |
| 5 | DFG Related Schemes | 1. Adaptations, including statutory DFG grants<br>2. Discretionary use of DFG<br>3. Handyperson services<br>4. Other | The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.<br><br>The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate |
| 6 | Enablers for Integration | 1. Data Integration<br>2. System IT Interoperability<br>3. Programme management<br>4. Research and evaluation<br>5. Workforce development<br>6. New governance arrangements<br>7. Voluntary Sector Business Development<br>8. Joint commissioning infrastructure<br>9. Integrated models of provision<br>10. Other | Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes.<br><br>Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others. |
| 7 | High Impact Change Model for Managing Transfer of Care | 1. Early Discharge Planning<br>2. Monitoring and responding to system demand and capacity<br>3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge<br>4. Home First/Discharge to Assess - process support/core costs<br>5. Flexible working patterns (including 7 day working)<br>6. Trusted Assessment<br>7. Engagement and Choice<br>8. Improved discharge to Care Homes<br>9. Housing and related services<br>10. Red Bag scheme<br>11. Other | The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section. |
| 8 | Home Care or Domiciliary Care | 1. Domiciliary care packages<br>2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)<br>3. Short term domiciliary care (without reablement input)<br>4. Domiciliary care workforce development<br>5. Other | A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services. |
| 9 | Housing Related Schemes | | This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units. |
| 10 | Integrated Care Planning and Navigation | 1. Care navigation and planning<br>2. Assessment teams/joint assessment<br>3. Support for implementation of anticipatory care<br>4. Other | Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals.<br><br>Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams.<br><br>Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside. |
| 11 | Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery) | 1. Bed-based intermediate care with rehabilitation (to support discharge)<br>2. Bed-based intermediate care with reablement (to support discharge)<br>3. Bed-based intermediate care with rehabilitation (to support admission avoidance)<br>4. Bed-based intermediate care with reablement (to support admissions avoidance)<br>5. Bed-based intermediate care with rehabilitation accepting step up and step down users<br>6. Bed-based intermediate care with reablement accepting step up and step down users<br>7. Other | Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. |
| 12 | Home-based intermediate care services | 1. Reablement at home (to support discharge)<br>2. Reablement at home (to prevent admission to hospital or residential care)<br>3. Reablement at home (accepting step up and step down users)<br>4. Rehabilitation at home (to support discharge)<br>5. Rehabilitation at home (to prevent admission to hospital or residential care)<br>6. Rehabilitation at home (accepting step up and step down users)<br>7. Joint reablement and rehabilitation service (to support discharge)<br>8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)<br>9. Joint reablement and rehabilitation service (accepting step up and step down users)<br>10. Other | Provides support in your own home to improve your confidence and ability to live as independently as possible |
| 13 | Urgent Community Response | | Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. |
| 14 | Personalised Budgeting and Commissioning | | Various person centred approaches to commissioning and budgeting, including direct payments. |
| 15 | Personalised Care at Home | 1. Mental health /wellbeing<br>2. Physical health/wellbeing<br>3. Other | Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type. |
| 16 | Prevention / Early Intervention | 1. Social Prescribing<br>2. Risk Stratification<br>3. Choice Policy<br>4. Other | Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being. |
| 17 | Residential Placements | 1. Supported housing<br>2. Learning disability<br>3. Extra care<br>4. Care home<br>5. Nursing home<br>6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement<br>7. Short term residential care (without rehabilitation or reablement input)<br>8. Other | Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home. |
| 18 | Workforce recruitment and retention | 1. Improve retention of existing workforce<br>2. Local recruitment initiatives<br>3. Increase hours worked by existing workforce<br>4. Additional or redeployed capacity from current care workers<br>5. Other | These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work. |
| 19 | Other | | Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column. |

| Scheme type | Units |
|---|---|
| Assistive Technologies and Equipment | Number of beneficiaries |
| Home Care and Domiciliary Care | Hours of care (Unless short-term in which case it is packages) |
| Bed Based Intermediate Care Services | Number of placements |
| Home Based Intermeditate Care Services | Packages |
| Residential Placements | Number of beds/placements |
| DFG Related Schemes | Number of adaptations funded/people supported |
| Workforce Recruitment and Retention | WTE's gained |
| Carers Services | Beneficiaries |

# Better Care Fund 2023-25 Template

## 6. Metrics for 2023-24

Selected Health and Wellbeing Board: Barking and Dagenham

### 8.1 Avoidable admissions

*Q4 Actual not available at time of publication

| | | 2022-23 Q1 Actual | 2022-23 Q2 Actual | 2022-23 Q3 Actual | 2022-23 Q4 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Indirectly standardised rate (ISR) of admissions per 100,000 population<br><br>(See Guidance) | Indicator value | 308.9 | 262.2 | 238.1 | 162.4 | Given performance target in 2022/23 was not met, the indicator will remain the same at 691 FYE for 23/24. | UCR response is now embedded in the local service offer and has been over performing against the 2-hour target (87%/target 70%). Primary Care are reinstating preventative reveiws, interventions, testing to monitor LTCs and identify those at risk through conditions such as hypertension. There is aslo a focus on targeting those who are at higher risk |
| | Number of Admissions | 489 | 415 | 377 | - | | |
| | Population | 212,906 | 212,906 | 212,906 | 212,906 | | |
| | | 2023-24 Q1 Plan | 2023-24 Q2 Plan | 2023-24 Q3 Plan | 2023-24 Q4 Plan | | |
| | Indicator value | 181.2 | 180.5 | 173.2 | 156.5 | | |

>> link to NHS Digital webpage (for more detailed guidance)

### 8.2 Falls

| | | 2021-22 Actual | 2022-23 estimated | 2023-24 Plan | Rationale for ambition | Local plan to meet ambition |
|---|---|---|---|---|---|---|
| Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | Indicator value | 1,966.1 | | | Awaiting BI input. There is an anticipated a 2% target redcution of emergency admissions. | B&D in the last 2 years has commissioned and developed a range of falls prevention and intervention services. This includes Strength and Balance classes run by Age UK, supporting people who are at risk of a future fall, delivered face to face in community venues and online. Community Health services now offer both community |
| | Count | 370 | | | | |
| | Population | 19,123 | | | | |

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

### 8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

| | | 2022-23 Q1 Actual | 2022-23 Q2 Actual | 2022-23 Q3 Actual | 2021-22 Q4 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | Quarter (%) | 93.3% | 93.6% | 93.8% | 89.1% | 93.6% target based on an average of 22/23 performance. | The system continues to develop the Integrated Discharge Hub (IDH) that supports smoother and more timely discharge to pathways 1-3. The service combined the Discharge Co-ordination Unit and the Hospital Discharge Service in 2021 and continues to develop the co-ordination function and single point of access function. Moving forward, it is |
| | Numerator | 3,450 | 3,417 | 3,495 | 2,007 | | |
| | Denominator | 3,697 | 3,651 | 3,725 | 2,254 | | |
| | | 2023-24 Q1 Plan | 2023-24 Q2 Plan | 2023-24 Q3 Plan | 2023-24 Q4 Plan | | |
| | Quarter (%) | | | | | | |
| | Numerator | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Denominator | | | | | | anticipated that the IDH will co-ordinate |

## 8.4 Residential Admissions

| | | 2021-22 Actual | 2022-23 Plan | 2022-23 estimated | 2023-24 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual Rate | 651.3 | 666.7 | 775.3 | 708.0 | The target has been increased from 135 to 145. During 2022-23, approximately 157 people were admitted for long term care and the target level was exceeded. Demand is predicted to remain high in 2023-24, based on local demographics and | An increased proportion of admissions are from hospital discharges for people with complex and challenging needs. Despite limited capacity in the care market for such cases we continue to work with our system partners to address these issues. There |
| | Numerator | 129 | 135 | 157 | 145 | | |
| | Denominator | 19,807 | 20,249 | 20,249 | 20,481 | | |

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

## 8.5 Reablement

| | | 2021-22 Actual | 2022-23 Plan | 2022-23 estimated | 2023-24 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 82.9% | 83.9% | 81.5% | 84.1% | The target of 84% has been retained. The metric has underperformed in recent years and the target remains a stretch one. The proportion of people aged 85 years and older in the cohort increased over the last two years. However, reablement is least | The number of people discharged into short-term crisis services remains high, as the service is offered to as many people as possible. There are a range of commissioned and operational teams supporting this metric, including crisis |
| | Numerator | 131 | 130 | 128 | 132 | | |
| | Denominator | 158 | 155 | 157 | 157 | | |

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

Barking and Dagenham

| **Key considerations for meeting the planning requirement**<br>These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) | **Confirmed through** | **Please confirm whether your BCF plan meets the Planning Requirement?** | **Please note any supporting documents referred to and relevant page numbers to assist the assurers** | **Where the Planning requirement is not met, please note the actions in place towards meeting the requirement** | **Where the Planning requirement is not met, please note the anticipated timeframe for meeting it** |
|---|---|---|---|---|---|
| Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11*<br><br>Has the HWB approved the plan/delegated approval? *Paragraph 11*<br><br>Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11*<br><br>Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?<br><br>Have all elements of the Planning template been completed? *Paragraph 12* | Expenditure plan<br><br>Expenditure plan<br><br>Narrative plan<br><br>Validation of submitted plans<br><br>Expenditure plan, narrative plan | Yes | See narrative plan and expenditure plan | | |
| Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:<br><br>• How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13*<br><br>• The approach to joint commissioning *Paragraph 13*<br><br>• How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include<br>- How equality impacts of the local BCF plan have been considered *Paragraph 14*<br><br>- Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14*<br><br>The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15* | Narrative plan | Yes | See narrative plan | | |
| Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33*<br><br>• Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33*<br><br>• In two tier areas, has:<br>- Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or<br>- The funding been passed in its entirety to district councils? *Paragraph 34* | Expenditure plan<br><br>Narrative plan<br><br>Expenditure plan | Yes | See narrative plan and expenditure plan | | |
| Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16*<br><br>Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19*<br><br>Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19*<br><br>Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* | Narrative plan<br><br>Expenditure plan<br><br>Narrative plan<br><br>Expenditure plan, narrative plan | Yes | See narrative plan and expenditure plan | | |

| | | | | | |
|---|---|---|---|---|---|
| Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41*<br><br>Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41*<br><br>Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44*<br><br>Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'?<br>If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51*<br><br>Is the plan for spending the additonal discharge grant in line with grant conditions? | Expenditure plan<br><br>Narrative and Expenditure plans<br><br>Narrative plan<br><br>Narrative and Expenditure plans | Yes | See narrative plan and expenditure plan | | |
| Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21*<br><br>Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22*<br><br>Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24*<br><br>Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*<br><br>Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23* | Narrative plan<br><br>Expenditure plan<br><br>Narrative plan<br><br>Expenditure plan, narrative plan<br><br>Expenditure plan<br><br>Narrative plan | Yes | See narrative plan and expenditure plan | | |
| Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55* | Auto-validated on the expenditure plan | Yes | See expenditure plan | | |

| | | | | | |
|---|---|---|---|---|---|
| Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12*<br><br>Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12*<br><br>Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73*<br><br>Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51*<br><br>Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41*<br><br>Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13*<br><br>Has funding for the following from the NHS contribution been identified for the area:<br>- Implementation of Care Act duties?<br>- Funding dedicated to carer-specific support?<br>- Reablement? *Paragraph 12* | Auto-validated in the expenditure plan<br>Expenditure plan<br><br>Expenditure plan<br><br>Expenditure plan<br><br>Expenditure plan<br><br>Narrative plans, expenditure plan<br><br>Expenditure plan | Yes | See narrative plan and expenditure plan | | |
| Have stretching ambitions been agreed locally for all BCF metrics based on:<br><br>- current performance (from locally derived and published data)<br>- local priorities, expected demand and capacity<br>- planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59*<br><br>Is there a clear narrative for each metric setting out:<br>- supporting rationales for the ambition set,<br>- plans for achieving these ambitions, and<br>- how BCF funded services will support this? *Paragraph 57* | Expenditure plan<br><br>Expenditure plan | Yes | See expenditure plan | | |