Open Agenda

Health and Wellbeing Board

Wednesday 21 September 2022
9.00 am
This will be a virtual meeting.

Membership

Councillor Kieron Williams (Chair)	Leader of the Council
Dr Nancy Kuchemann (Vice-Chair)	GP and NHS SE London
Councillor Evelyn Akoto	Cabinet Member for Health and Wellbeing
Councillor Jasmine Ali	Deputy Leader and Cabinet Member for Children, Young People and Education
Councillor Dora Dixon-Fyle MBE	Cabinet Member for Community Safety
Councillor Maria Linforth-Hall	Opposition Spokesperson for Health
Anood Al-Samerai	Community Southwark
Sarah Austin	Chief Executive Integrated and Specialist Medicine for Guy's and St Thomas' NHS Foundation Trust
David Bradley	Chief Executive of South London and Maudsley NHS Foundation Trust
Cassie Buchanan	Southwark Headteachers Representative
Shamsur Choudhury	Healthwatch Southwark
Clive Kay	Chief Executive, King's College Hospital NHS Foundation Trust
Sangeeta Leahy	Director of Public Health , Southwark
Althea Loderick	Chief Executive, Southwark
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Andrew Ratcliffe	Guy's and St. Thomas' Foundation
Martin Wilkinson	Chief Operating Officer, Southwark, NHS SEL Integrated Care Board

INFORMATION FOR MEMBERS OF THE PUBLIC

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Contact

Email: maria.lugangira@southwark.gov.uk
Webpage: Health and Wellbeing Board - Southwark Council

Members of the committee are summoned to attend this meeting
Althea Loderick
Chief Executive
Date: 13 September 2022

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Wednesday 21 September 2022
9.00 am
This will be a virtual meeting.

Order of Business

Item No.	Title	Page No.
1.	**WELCOME AND INTRODUCTIONS**	
2.	**APOLOGIES** To receive any apologies for absence.	
3.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in the meeting.	
4.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
5.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
6.	**MINUTES** To agree as a correct record the open minutes of the meeting held on 4 July 2022.	1 - 7

Item No.	Title	Page No.

7. PUBLIC QUESTION TIME (15 MINUTES)

To receive any question from members of the public which have been submitted in advance of the meeting in accordance with the procedure rules.

8. BETTER CARE FUND 2022/23 8 - 67

9. ANY OTHER BUSINESS

10. NEXT MEETING

17 November 2022

Date: 13 September 2022

HEALTH AND WELLBEING BOARD

MINUTES of the Health and Wellbeing Board held on Monday 4 July 2022 at 10.00 am at Ground floor meeting rooms, 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Kieron Williams (Chair)
Councillor Evelyn Akoto
Councillor Jasmine Ali
Councillor Maria Linforth-Hall
Anood Al-Samerai
Sarah Austin
Cassie Buchanan
Shamsur Choudhury
Sangeeta Leahy
Althea Loderick
David Quirke-Thornton
Martin Wilkinson

OFFICER SUPPORT: Chris Williamson – Head of Health and Wellbeing
Maria Lugangira – Principal Constitutional Officer

1. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

2. APOLOGIES

Apologies for absence were received from

- Councillor Dora Dixon-Fyle
- Dr Nancy Kuchemann
- David Bradley
- Andrew Radcliffe
- Clive Kay

3. CONFIRMATION OF VOTING MEMBERS

Those listed as present were confirmed as the voting members.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

There were none.

5. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were none.

6. MINUTES

RESOLVED - That the minutes of the meeting held on 13 January 2022, be approved as a correct record of the meeting.

7. PUBLIC QUESTION TIME (15 MINUTES)

There were none.

8. UPDATED JOINT HEALTH AND WELLBEING STRATEGY

The Board considered the updated Joint Health and Wellbeing Strategy. The focus of the strategy is on tackling health inequalities that lead to differences in health and life expectancy within the borough.

The strategy was adopted by the Health and Wellbeing Board in 2015 and ran until 2020. In June 2021, the Board agreed that a steering group would be established to develop an updated strategy. The steering consisted of leadership from Southwark Council's Public Health Team, Partnership Southwark, South East London CCG, Healthwatch Southwark and Community Southwark.

Amongst the key points raised by the Board on the strategy – they requested;

- That the Strategic priorities are singed off by the Board
- Clarity on what elements of the strategy fall within the remint of Partnership Southwark and what do they approve? Is there duplication with HWBB?
- Focus in the strategy on what works for best Southwark residents and what works on a borough level
- Further detail around the timeframe and an action plan on the

implementation of the Health and Care Plan.

RESOLVED - The Southwark Health and Wellbeing Board adopt the updated Joint Health and Wellbeing Strategy.

9. ANNUAL PUBLIC HEALTH REPORT

The Board considered the Annual Public Health Report (APHR), which is a mechanism for informing partners and residents about the health of Southwark's communities. It also provides evidence on key health and wellbeing needs that should be prioritised in the forthcoming year.

This year's Annual Public Health Report aimed to celebrate the value of partnership working during the pandemic.

Partnership working enabled;

- **the delivery of the Outbreak and Prevention Control Plan** in order to protect residents, for example;
  - **Prevent -** Southwark's Community Health Ambassadors Network set up in October 2020, with over 100 ambassadors.
  - **OPCE Communications –** OPCE Communications and Engagement group brought together a range of partners across the council, NHS and Community Southwark to understand the local picture and inform hyper-local campaigns on testing, vaccinations and to support local businesses

- **the delivery of a range of other programmes designed to support Southwark residents.** This looked at areas where partnership working had helped to reduce the negative impacts of COVID-19 on our residents across three areas: food insecurity, education and learning and older people.

RESOLVED - That the Health and Wellbeing Board note the findings of the Annual Public Health Report, and commit to the recommendations.

10. PARTNERSHIP SOUTHWARK LEADERSHIP ARRANGEMENTS

The Chief Operating Officer of Southwark, NHS SEL Integrated Care Board, provided a brief verbal update.

He explained that the Partnership Southwark Strategic Board would be Co-chaired by Cllr Evelyn Akoto and Dr Nancy Küchemann and that their first public meeting was due to place on 7 July 2022. At this meeting, the Board would be considering, amongst other matters, its Terms of Reference, the working

arrangements within ICS and the wider Integrated Care System.

A more detailed updated will be reported back to the next appropriate meeting of the Health Wellbeing Board.

11. BETTER CARE FUND: 2021/22 YEAR END REPORT AND UPDATE ON PLANNING FOR 2022/23

The Board considered the report, which provided confirmation that the 4 key national Better Care Fund conditions for 2021/22 had been met. It further provided an update on the BCF planning process for 2022/23, highlighting the delay in launching the national planning process. The report also set out the intention of expanding the BCF in Southwark.

Amongst the key points raised by the Board were;

- They felt the governance arrangements needed strengthening;
  - what the key stages in the process are before the BFC is presented to the Health and wellbeing Board

- Further clarity and detail was required around;
  - ensuring it's clear what the value of the BCF for 2022/23 is and what the actual plan was for this year
  - the expansion of the BCF i.e what exactly was being expanded.

It was explained to the Board that the timetable for submission had not yet been released and that as such it may be necessary to convene a special meeting of the Board to sign off the plan prior to submission to NHSE.

RESOLVED – That the Health and Wellbeing Board;

1. **notes the BCF 2021/22 year-end report as set out in paragraph 11.**

2. **notes the update on the national 2022/23 BCF planning process as set out in paragraph 7 and note the intention in Southwark to expand the BCF as set out in paragraphs 20 to 22.**

3. **confirms the preferred governance process for signing off the 2022/23 BCF set out in paragraph 10.**

12. COVID-19 UPDATE REPORT

The Board considered the COVID-19 monitoring report, which presented headline statistics for current local and regional COVID-19 data.

Key headline messages:

- Confirmed case numbers continued to increase; there had been 518 confirmed cases of COVID-19 in the week to 17 June. The ONS estimated 1 in 40 people in London had COVID-19 as at 11 June.

- The number of hospital inpatients with COVID-19 across London had risen in recent weeks.

Vaccination levels were now almost stationary for first, second and booster doses, with levels comparable to similar boroughs such as Lambeth.

- First Dose Coverage: 67% of those aged 12+ (over 206,000 doses delivered)
- Second Dose Coverage: 64% of those aged 12+ (over 197,000 doses delivered)
- Booster Dose Coverage: 78% of those eligible (over 148,000 doses delivered)

Local work was underway to integrate on-going COVID-19 vaccination with other key health interventions**.**

- Southwark continued with its 'evergreen offer'; i.e. anyone who had not yet had a vaccine continued to be welcome when eligible for one.

- Several health 'pop ups' would be run across the borough this summer. The focus being on delivering key health messages, such as the importance of the 'Vital 5' as well as the offer of a COVID vaccination.

- A proposal for co-administration of flu and COVID vaccines later this year by GP practices had gone to the GP Federations for discussion. The aim, to have the model for delivery agreed by end of July, and be in a position to mobilise in September.

RESOLVED - The board note the contents of the COVID-19 Monitoring Report.

13. PHARMACEUTICAL NEEDS ASSESSMENT (PNA) UPDATE

The Board considered the Pharmaceutical Needs Assessment (PNA) report, which gave an update on pharmaceutical services provided in Southwark.

The PNA seeks to enable commissioners and providers to better meet current need within Southwark and take steps to ensure that needs continue to be met in the future.

The report forms part of the borough's Joint Strategic Needs Assessment (JSNA) work programme, and informs the Joint Health & Wellbeing Strategy (JHWS) and it is envisaged other local action to improve health and wellbeing in Southwark.

The PNA process was being led by the Public Health team in Southwark Council and overseen by a reference group established in October 2021.

The draft PNA was currently in the required statutory 60 day consultation phase which is an online questionnaire involving members of the public and other interested parties. The closing date is 9th August 2022

RESOLVED -

1. **The Board note the progress of the Pharmaceutical Needs Assessment (PNA) to date.**

2. **The Board are aware that the results of the consultation and amended draft PNA will be shared towards the end of August 2022.**

3. **The Board virtually approve the revised draft as the final version of the PNA for publication on or before 30 September 2022, in order to meet the statutory deadline for publication of 1st October 2022**

14. ANY OTHER BUSINESS

There was none.

15. NEXT MEETING

17 November 2022

Meeting ended at 12.00 pm

CHAIR:

DATED:

Agenda Item 8

Item No.	Classification: Open	Date: 21 September 2022	Meeting Name: Health and Wellbeing Board
Report title:		Better Care Fund 2022/23	
Ward(s) or groups affected:		All	
From:		Martin Wilkinson, Chief Operating Officer, Southwark, NHS SEL Integrated Care Board Genette Laws, Director of Commissioning, Children and Adults, Southwark Council	

RECOMMENDATIONS

1. That the Health and Wellbeing Board agrees to the submission of the Better Care Fund (BCF) Planning templates 2022/23 (appendices 1 to 3) for approval under the national BCF assurance process.

BACKGROUND INFORMATION

2. The Better Care Fund (BCF) was first established in 2015/16 as a national policy initiative to drive forward the integration of health and social care services by requiring local councils and CCGs to agree a pooled budget and an associated plan for community based health and care services. It is a requirement that the BCF plan is agreed by the Council, Integrated Care Board (ICB) and the Health and Wellbeing Board and submitted to NHSE for assurance and agreement.

3. At the meeting of the board on 4th July 2022 an update was provided on the BCF planning process for 2022/23, highlighting the delay in launching the national planning process. The report set out the intention provisionally agreed between partners (subject to the planning requirements) to roll forward existing plans and budgets and invest expected growth in priority areas. The report also set out the intention to move additional budgets into the BCF to create a larger pooled budget above the minimum required level for Southwark's BCF.

4. The board agreed to a governance process for the submission under which a special meeting of the board would be convened to agree the BCF before submission to NHSE. This was considered more appropriate than the permitted alternative of agreement under delegated authority followed by retrospective reporting to the next planned meeting.

5. The BCF planning framework was issued on 19th July with a requirement to submit completed planning documents by 26th September. The planning requirements were not deemed to introduce any changes impacting on the provisional expenditure plans, but did introduce new requirements to set out information in the narrative plan.

6. The value of the BCF for 2022/23 is £48.7m, including £2.6m new additional funding above the minimum required level.

7. Further background to this year's BCF and changes from previous years is set out in the templates.

KEY ISSUES FOR CONSIDERATION

2022/23 BCF

8. Key issues for consideration are set out in the BCF plan narrative template (appendix 1). Further detailed information is set out in the BCF Finance and Metrics template (appendix 2).

9. These plans have been agreed through the respective governance processes of the council and the ICB and now need to be agreed by the Health and Wellbeing Board.

Intermediate Care template

10. Alongside this year's BCF submission local areas were asked to provide data for a national return on demand and capacity in intermediate care services. This is attached in appendix 3. Although not formally part of the BCF it is a requirement that this return is agreed alongside the BCF.

11. It should be noted that there are limitations to this data because existing systems do not readily provide data in the requested format, and assumptions have been stated to that effect in the return. It is anticipated that the return will be further refined next year, and local areas will be able to adapt systems to collect data that more accurately presents useful information on likely demand and supply pressures. In the meantime, local commissioners will continue to seek to identify and address supply and demand issues in intermediate care using local intelligence, with the aim of ensuring delayed transfers of care resulting from any shortage of suitable provision is minimised.

2023/24 and 2024/25 BCF

12. The national BCF team have indicated that the intention is to have a two year BCF plan in 2023/24, with planning requirements to be published in advance of the financial year. This will be a welcome development for planning and engagement purposes. It is also anticipated that there may be some developments in the scope of the BCF so that it supports the

national objective of ensuring greater alignment of resources to strengthen integration at a place level under the Integrated Care System (ICS) arrangements.

13. Local planning for 2023/24 will commence directly after the agreement of the 2022/23 plan. Partners have already agreed in principle to consider further expansion of the BCF above minimum required levels in 2023/24, building on the learning from the current year in which voluntary expansion is being piloted with £2.6m worth of budgets in 2022/23 as set out in the narrative template.

Policy framework implications

14. The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2022-23 on 19 July 2022. The government issued the document "BCF Planning Requirements 2022/23" to local systems requiring the development of plans at Health and Wellbeing Board level. The document sets out the purpose of the BCF in terms of driving forward the national integration agenda. The BCF plan submitted reflects local policy on integration as set out in the Partnership Southwark Recovery Plan and is consistent with the national framework.

Community, equalities (including socio-economic) and health impacts

Community impact statement

15. The BCF plan protects current services funded through the core BCF which provide essential community support for people with health and social care needs. This has benefit to all people with protected characteristics, particularly services provided for older people, and people with disabilities and mental ill-health. The BCF also funds a range of voluntary sector services promoting community resilience, including the older people's community hub.

16. The BCF is focussed on the delivery of the objectives of the Partnership Southwark Recovery Plan through the provision of integrated neighbourhood support models increasing community resilience, improving outcomes and addressing health inequalities.

17. Other beneficiaries of this investment are the homecare workforce who have been paid the London living wage since April 2018 under Southwark's ethical care charter. This workforce has a high proportion of women and those from the black and minority ethnic communities.

Equalities (including socio-economic) impact statement

18. Section 8 of the narrative plan sets out how the BCF plan contributes to the equalities objectives of the Partnership Southwark Recovery Plan.

Health impact statement

19. The Better Care Fund provides funding for a range of core community-based health and social care services which have the objective of promoting improved health and wellbeing outcomes of all Southwark residents in need of services.

20. Section 8 of the plan sets out how the BCF aligns to the delivery of the Health and Wellbeing Strategy.

Climate change implications

21. There are no specific climate change implications covered in the BCF plan, although providers will have specific initiatives linked to environmental goals. For example, the Integrated Community Equipment Service has a key objective around promoting recycling of used equipment which reduces both costs and environmental impact.

Resource implications

22. The table in annex 1 of the narrative template sets out a detailed summary of changes in the BCF budget for 2022/23 compared to 2021/22.

Consultation

23. As set out in the section “Bodies involved in preparing the plan” of the narrative plan on page 1.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Strategic Director of Finance and Governance (24EN202223)

24. The Strategic Director of Finance and Governance notes the recommendations of this report to agree the submission of the 2022-23 BCF Planning template. The majority of the plan includes the rollover of pre-existing plans plus the allocation of additional inflationary increases received of £1.4m for BCF and £0.5 for IBCF as per narrative plan in Appendix 1.

25. The Strategic Director of Finance and Governance also notes the additional voluntary contributions included in the schemes by both the ICB and the council.

26. The income streams of the Better Care Fund and Improved Better Care Fund represent significant part of the council’s and ICB’s income streams.

Therefore the intention to have a two year BCF plan in 2023/24 with planning requirements to be published in advance of the financial year is welcomed as described in para 13.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
BCF background documents	160 Tooley Street, London SE1 2QH	Adrian Ward Adrian.ward@selondonics.nhs.uk

APPENDICES

No.	Title
Appendix 1	BCF 2022/23 Narrative Plan Template
Appendix 2	BCF 2022/23 Finance and Metrics Template
Appendix 3	Intermediate Care Demand and Capacity Template

AUDIT TRAIL

Lead Officer	Martin Wilkinson, Chief Operating Officer, Southwark, NHS SEL Integrated Care Board Genette Laws, Director of Commissioning, Children's and Adults, Southwark Council
Report Author	Adrian Ward, Head of Place PMO (Southwark), NHS South East London Integrated Care Board
Version	Final
Dated	15/9/22
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Governance	No	-
Strategic Director of Finance and Governance	-	Yes
Cabinet Member	No	-
Date final report sent to Constitutional Team		16 September 2022

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Better Care Fund 2022/23

Southwark

Narrative template

Draft v1.4 15/9/22

Note on timing of BCF Plan

The BCF plan is required to meet the requirements set out in national BCF planning guidance, which include a strong focus on the integration of services to improve outcomes, by supporting people to live in their own home, avoiding admission to hospital and care homes and ensuring support for hospital discharge is timely and effective.

In the absence of national planning guidance at the start of 2022/23, partners agreed to roll over much of the 2021/22 BCF plan (agreed by the Health and Wellbeing Board in November 2021). Provisional agreements were also made on the use of anticipated uplifts to address cost pressures and fund new schemes, all subject to the guidance being issued and plans receiving assurance. This approach was presented to the Health and Wellbeing Board in July 2022.

The planning guidance was issued on 19 July with a submission date of 26 September and these templates reflect this guidance. Whilst the guidance did not introduce changes that were deemed to require a review of the provisional funding decisions, there was a change in the emphasis and required content of narrative plans and the introduction of analysis of demand and capacity in Intermediate Care.

Contents:

1. Cover

Health and Wellbeing Board(s): Southwark

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils): Partnership Southwark members including Integrated Care Board, Southwark Council Public Health, Adults and Children's Services, Housing, Mental Health, Acute and Community Trusts and VCS.

How have you gone about involving these stakeholders? Engagement via Partnership Southwark and Health and Wellbeing Board discussions on strategy, and underpinning engagement on Partnership Southwark strategies including the Recovery Plan.

2. Executive summary

The Better Care Fund (BCF) is a pooled budget held between the council and the NHS that funds a range of core community based health and adult social care services. It was originally formed in 2015/16 by consolidating a range of existing funding streams for health and social care. It is a mandatory pooled budget to which the NHS and Council are required to make stipulated minimum contributions, with minimum ringfenced amounts to be spent on social care and health. The value of the BCF for 2022/23 is £48.7m, including £2.7m new additional funding above the minimum required level.

Key BCF priorities for 2022/23

The high-level priorities for the BCF are unchanged from previous plans that have been rolled forward into 2022/23. These are to provide funding for a range of out of hospital services to provide integrated person centred integrated care that will:

- Support people to live independently and safely in their own home
- Provide community support that prevent or delay people from needing higher levels of support
- Prevent avoidable admissions to hospital and care homes
- Support timely and effective transfers of care from hospital
- Improve population health and wellbeing outcomes and help tackle health inequalities by targeting resources at those most in need of support

More specifically for the current year, there are key system priorities that the BCF is closely aligned to:

- supporting the bedding in of the South East London Integrated Care System, including the Integrated Care Board Southwark borough team and the formalised **Partnership Southwark** arrangements, which were formally established on 1st July. In particular, our key priority is supporting the Partnership Southwark place-based programme for the development of integrated health and care services to improve population health
- supporting a reduction in health inequalities in line with the refreshed **Health and Wellbeing Strategy**, and aligned to the future **Southwark Health and Care Plan,** so that the BCF Plan will respond to this and feed into the South East London integrated care plan
- strengthening the **alignment of resources** and shared understanding of collective budgets across Partnership Southwark by considering further expansion of the BCF pooled budget and assisting the further development of the joint commissioning approach
- consolidating progress on the Partnership Southwark Recovery Plan with particular focus on **Age Well and Care Well workstreams**, building on the learning from the pandemic
- support further development of the **neighbourhood model** to promote integrated multi-disciplinary working focussed on outcomes and community needs
- strengthen whole **system resilience** in the face of anticipated intensive pressures, particularly over the winter period, including pressures arising from demand

(including possible flu, covid and cost of living pressures), cost pressures, workforce and funding issues.

- continued improvement to the **hospital discharge system,** including the development of the multi-disciplinary internal flow hubs and home first/ discharge to assess, reducing delayed transfers of care and avoidable long lengths of stay. This will both improve outcomes for patients and increase acute capacity.
- develop the support offer for **unpaid carers** using BCF resources as set out in section 6.

Changes to National BCF Priorities

As set out in section 5, the local priorities of the BCF also align to the revised national statement of BCF objectives set out in the July planning guidance to:

- **Enable people to stay well, safe and independent at home for longer**
- **Provide the right care in the right place at the right time**

Key changes to BCF budgets - 2022/23

A full summary of BCF budget changes since 2021/22 is set out in annex 1.

Although the BCF predominantly consists of schemes and budgets that have rolled forward from previous years there are new features to note for 2022/23:

Additional Contributions by the ICB and Council

In previous years the total value of the BCF has been set locally at the minimum level for Southwark under national planning guidance, this being the mandatory contribution of the council iBCF (Improved Better Care Fund) grant, and disabled facilities grant plus the minimum NHS contribution set by government formula. For 2022/23 it was agreed to exercise the option to add additional voluntary contributions above the minimum, adding services and their budgets that fit well within the BCF, thereby creating a larger pooled budget covering a greater proportion of the “Southwark £”. For 2022/23 the approach is being piloted with an additional £2.6m of existing spend being moved into the BCF, as set out in table 1 overleaf.

It should be noted that some of the budgets being brought into the BCF relate to areas that for historical reasons were part funded by the BCF and part funded from organisations’ (Council and ICB)/CCG) base budgets. The wider pooling rationalises this by making the service fully BCF funded (e.g. community equipment and telecare).

The addition of the community health falls service to the BCF reflects the importance attached to developing integrated approaches to falls prevention, a priority within the Age Well workstream.

Table 1: Additional contribution to the BCF above minimum - 2022/23

Additional council contributions:	**£000**
Council	
community equipment:	247
telecare:	445
Voluntary sector prevention:	483
Voluntary sector carers:	113
Total council:	**1,287**
CCG/ICB	
Community equipment:	1,201
@home community health:	191
Falls service:	821
Adjustments out:	(900)*
Total CCG/ICB:	**1,312**
Grand total additional contributions	**2,600**

*Note: The NHS growth is offset by £900,235 of service budgets transferred out of the BCF. This is because the ICB has changed the funding route for enhanced primary care access, which was part funded from the BCF but has been transferred directly to related Primary Care Network (PCN) budgets as part of an overall rationalisation. The previous budget for a care home pharmacist has also been transferred directly to the PCN budget as part of the wider PCN contract. Both services will be unaffected by this change. The Self-management budget has also been reduced by £100k to reflect actual spend although the required amount will be funded when services are re-commissioned.

Use of inflationary uplifts

The BCF Guidance confirmed annual uplifts in line with expected values that the BCF Planning Group had previously considered. The approach has been to target growth on agreed priority areas as follows:

Table 2: Use of annual uplift to CCG contribution (5.66%)

Council	**£'000**
Hospital discharge – discharge to assess:	250
Reablement OT team:	456
Reablement and nursing care home packages:	263
Telecare:	58
Total (Council)	**1,027**
CCG	
Enhanced rapid response and @home	362
Integrated community equipment growth	26
Tariff uplift neuro-rehab/EIS	9
Total (CCG)	**398**
Total uplift of CCG contribution	**1,424**

Table 3: Use of uplift in IBCF grant:

Council	**£'000**
Flexi Care	**525**

The iBCF grant is received by Councils for the provision of adult social care that is required to be pooled in the BCF. The £524,768 3% uplift in the IBCF grant has been assigned to Flexi Care:

Flexi Care (IBCF growth funding 2022/23)

Southwark's Housing and Social Care Partnership Board have agreed a new model of housing and care termed the provision 'Flexi Care'.

The Vision for Flexi Care is *'A community and neighbourhood approach to care and support that is delivered in an innovative, flexible and dynamic way'*

The aim of Flexi Care is to provide high quality and flexible care and support provision to residents, directed at those whose general needs housing is not adaptable to their care requirements. Allowing them to remain independent and engaged with the local community and 'flexing' their care and support based on their changing needs

The cohort of patients currently supported via the schemes are those aged 40 and upwards and capable of independent and semi-independent living. All residents are required to sign a tenancy agreement and will need capacity to do so. We support a range of people from low to high needs based on a banding system.

A full analysis of BCF budget changes between 2021/22 and 2022/23 is set out in **annex 1.**

3. Governance arrangement for the BCF

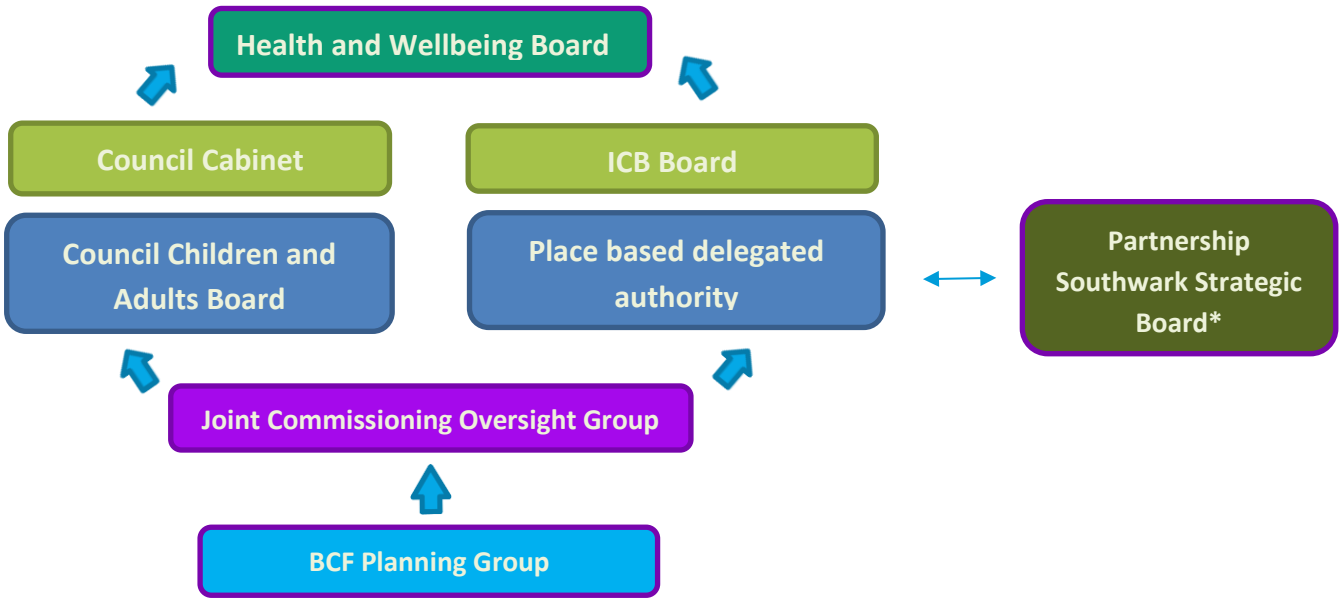
The BCF is agreed between the council and the ICB prior to approval by the Health and Wellbeing Board. After a draft has been agreed through the BCF Planning Group in consultation with stakeholders it is formally agreed through each organisation's respective governance requirements, then presented to the Health and Wellbeing Board. It is also subject to approval through a national BCF assurance process before being formally agreed.

The pooled budget arrangements are governed by a Section 75 agreement between the council and the CCG/ICB which sets out shared responsibilities to implement the planned spending as agreed. This Section 75 agreement is formally signed after the national approval letter. The BCF is subject to quarterly and year end reporting to NHSE, reviewed internally and agreed by the council and ICB before submission. Each scheme in the BCF is assigned a lead organisation responsible for the expenditure on that budget which is managed within the governance arrangements of the lead organisation.

In Southwark the BCF Planning Group has been set up to agree plans and oversee the high-level monitoring of the BCF on behalf of the Health and Wellbeing Board and to agree any changes to the use of funding. This group includes the Director of Adult Social Care, the council's Director of Commissioning for Children's and Adults and the ICB's Chief Operating Officer for Southwark on behalf of the Place Executive Lead as well as Finance leads.

Under revised place based governance arrangements following the formal establishment of the ICB a new Joint Commissioning Oversight Group has been established covering health, public health, adults and children's social care joint commissioning arrangements. The BCF Planning Group is a sub-group of this group. The diagram below is for illustrative purposes to provide context for the description of governance arrangements.

Governance Arrangements for the Southwark BCF

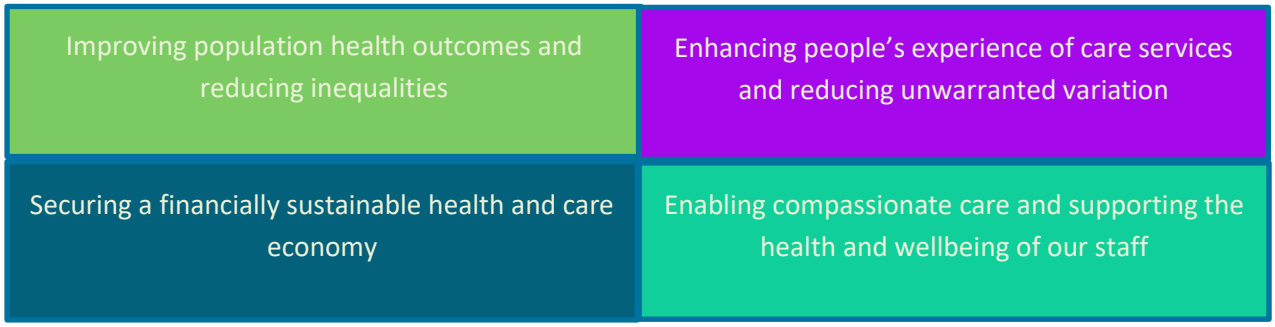


* Partnership Southwark Strategic Board helps shape the future strategic direction of the BCF as part of the delegation of ICB governance to local care partnerships.

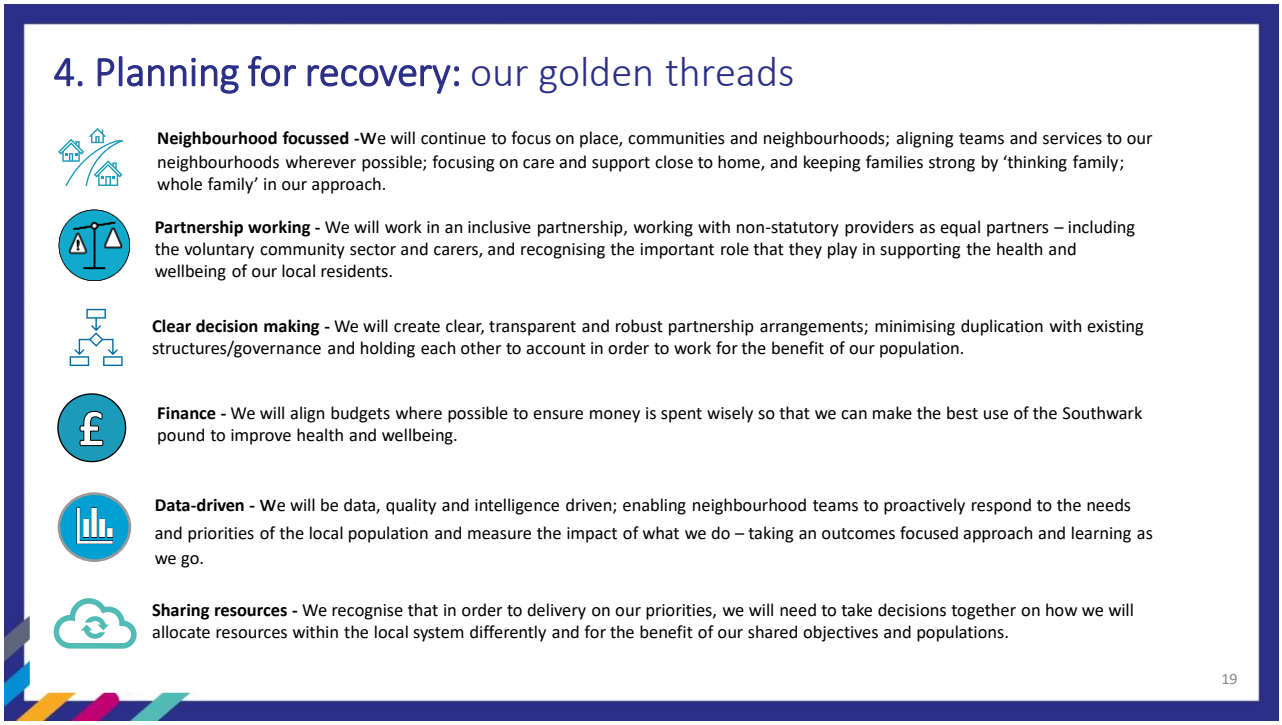
4. Overall BCF plan and approach to integration

Note: Following the formal establishment of Partnership Southwark as a sub-committee within the new SEL ICS structure from 1 July 2022 there will be a new **Southwark Heath and Care Plan** for the integration of health and care which partners will be working on during 2022/23. This plan will be focussed on the delivery of the recently refreshed **Health and Wellbeing Strategy** which is a key foundation to our approach to integration and joint commissioning, as set out in section 6. In the interim the approach to integration will be as set out in the Partnership Southwark Recovery Plan below:

The overall approach to integration in Southwark is driven through our local care partnership, Partnership Southwark. The partnership was first formed in May 2019 and brings together a range of health, care and anchor organisations with a view to working together with non-statutory providers and service users/carers in our communities. The overarching aim is to better join up services and tackle the causes of inequality and improve the health and wellbeing of Southwark residents. Partnership Southwark's Recovery Plan, which was signed off by the Partnership and Health and Wellbeing Board in September 2020, built on the work of the partnership pre-pandemic. It sought to use the experience of the first wave to reframe the partnership's work programme with a stronger focus on targeted approaches to addressing inequalities and a quadruple aim of:



Aside from short term recovery of services from COVID-19, the plan seeks to refocus our whole system efforts on tackling the health and wellbeing inequalities that were highlighted and exacerbated by the impact of COVID-19 on the population. The plan identifies 4 key population-based workstreams: **Start Well, Live Well, Age Well, Care Well** underpinned by key golden threads (overleaf):



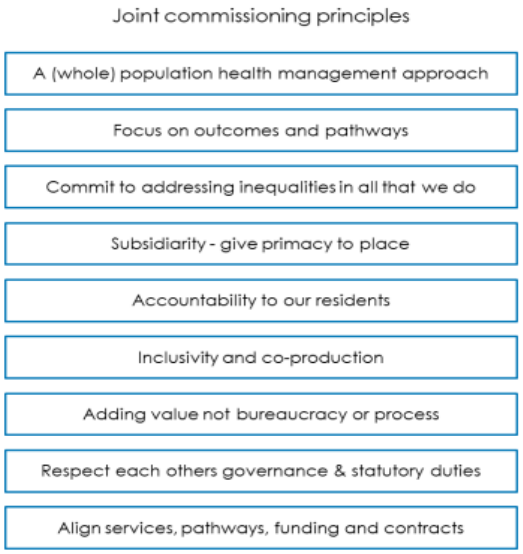
Approaches to joint/collaborative commissioning

Southwark council and the ICB have a well-established joint commissioning structure with teams responsible for delivering joint programmes to improve outcomes and address health inequalities for the population: older people and adults with complex needs; children and young people; and healthy populations. The team is jointly funded with a substantial contribution from the BCF. The primary care commissioning team is part of the overall structure (led by a joint-funded post) to help ensure cohesion, although the team is not jointly funded.

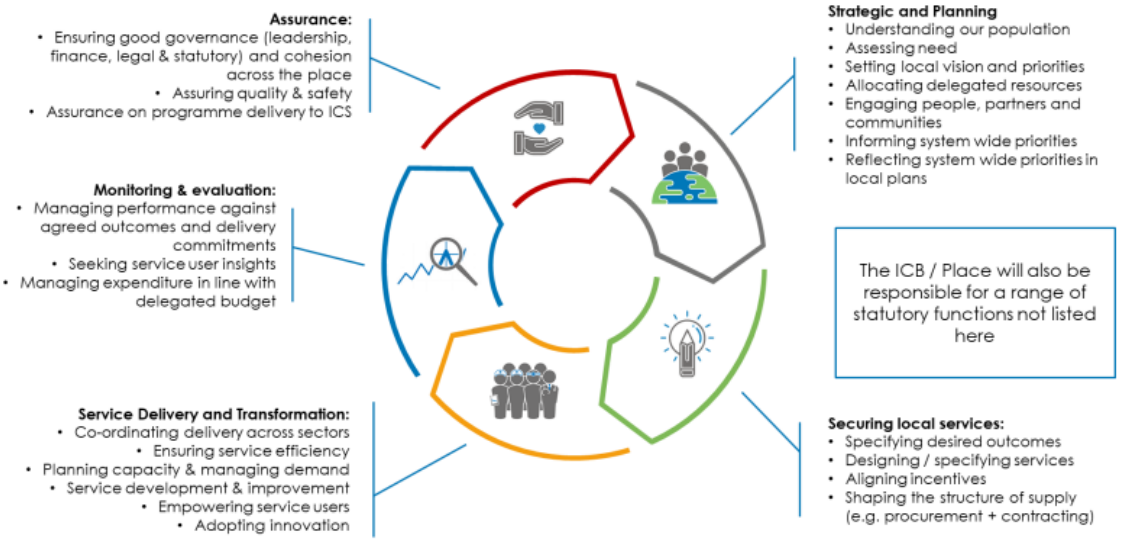
The joint commissioning teams works closely with the Partnership Southwark programme team that leads integrated programmes under the Start Well, Live Well, Age Well and Care Well programmes which are focussed on facilitating improved joint working between providers.

Building a consensus on further deepening the approach to integrated commissioning has been a key organisational development priority, supported by a Commissioning Strategy and Integration Board during 2021/22 which held workshops supported by external partners. This included agreeing key principles, a common framework for joint commissioning and planning progress against agreed "road map" milestones on an integration maturity matrix, and the development of integration demonstrator projects (see fig. 1). This work is ongoing under the new Partnership Southwark Strategic Board, overseen by the new Joint Commissioning Oversight Group and will be articulated through the development of the Partnership Southwark Health and Care Plan over 2022/23.

Fig 1: Joint Commissioning Principles and common framework for joint commissioning



We agreed a set of principles which would underpin the development of future joint commissioning arrangements and how we plan services



.....and discussed a common framework for joint commissioning, with the development of LCP functions underway to underpin the process and provide the necessary inputs

Key principles of the Bridges to Health and Wellbeing Approach

Partnership Southwark has previously agreed an approach to joint commissioning for improved population outcomes referred to as the Bridges to Health and Wellbeing model that was developed following extensive engagement. Whilst it was decided not to take a prescriptive approach to applying the methodology to all programmes, the model provides guiding principles that apply to all integrated workstreams:

1	**Organising the population into coherent groups –** grouping the population according to similar patterns of health and care need (i.e. 'population segments') and associated relevant outcomes is a sound basis for developing a population based approach
2	**Agreeing outcomes for population groups** - the development of an agreed outcomes framework for each population group/ segment, like the approach used for the frailty, dementia and end of life segment, provides partners with a common focus
3	**Whole system approach to deliver the outcomes -** population health and wellbeing outcomes can only be fully achieved by all partners working together as a single Southwark system.
4	**The integrated service models need to be holistic and person focused** – health, care and universal services focussed on working together on the whole need of a person or population rather than service focused. Co-production of new service models with the public and the use of personalised outcomes for individuals in their multi-disciplinary plans is a key element of this.
5	**Prevention -** we need to shift resources to prevention if outcomes are to improve. This will mean sharing the costs, risks and rewards of investment in prevention opportunities we have identified.
6	**Providers and commissioners will need to work together in new ways -** with formal and informal alliances where necessary to deliver outcomes on which they are jointly accountable. This will include high levels of collaboration, trust, and data and intelligence sharing.
7	**Workstreams to be aligned to outcomes frameworks –** we need a structured approach to incorporating the delivery of improved outcomes into the way services are developed. This covers not just existing and proposed Partnership Southwark workstreams, but any relevant workstreams and "business as usual" services.
8	**Evidence based and driven by shared data –** The new integrated service models need to be based on in depth needs analysis using shared data on individuals and populations, mapping of existing services, gaps and opportunities, knowledge of best practice etc.
9	**Aligning resources and commissioning -** We need to consider all resources available for populations to improve outcomes and consider the best way of configuring them that is the best use of the "Southwark £".
10	**Commissioning for outcomes and contractual changes -** There will inevitably be a need over time for the approach to contractual specifications and payment mechanisms to shift to reflect the focus on outcomes – however the need for these to be evolutionary rather than revolutionary is recognised, with clear mechanisms in place to address system risks

Developing the neighbourhood model in Southwark

A key aim of the integration strategy is to develop local networks that can provide person focussed co-ordinated care to those in need of support. This is summarised in the extract from the Recovery Plan below, and will be developed alongside the introduction of the Anticipatory Care model anticipated during 2022/23 as set out in section 5.

Further work to embed this approach will be articulated in the Health & Care Plan during 2022/23 as part of our system response to the Fuller Review.

5. Implementing the BCF Policy Objectives (national condition four)

National BCF Priorities

The BCF plan is aligned to the new twin priorities set in the July guidance as follows:

- **Enable people to stay well, safe and independent at home for longer** – through the funding of person centred community based services that prevent the deterioration of health and wellbeing and help reduce avoidable admissions to hospital or care homes. BCF funded schemes include:
    - Home care
    - Step up reablement and intermediate care including urgent response
    - Support to carers
    - Telecare and community equipment
    - VCS funding
    - Falls service incorporated into BCF from 22/23
    - Self-management funding for people with long term conditions
    - Flexi care

- **Provide the right care in the right place at the right time** – through the funding of timely and effective hospital discharge services including:
    - 7 day hospital discharge team
    - Internal flow hubs pursuing home first discharge to assess approach
    - Community Health @home service (hospital at home)
    - Step down reablement and intermediate care
    - Home care
    - Residential care and nursing care

Further development areas for reducing delayed transfers: High Impact Changes Model for transfers of care

The High Impact Changes Model is a framework for identifying potential improvements across key aspects of the hospital discharge process. The model is used as a tool in Southwark as a benchmark for good practice and to help identify service improvement priorities. A recent assessment against the criteria confirmed that current arrangements fall into the mature or established banding. Areas for potential further improvement to be explored include:

Change 1: Early discharge planning

- ensure people at high risk of admission have discharge plans in place
- ensure full compliance with the setting of expected dates of discharge and ensuring effective communication of this
- ensure new providers implement the red bag scheme promptly

Change 2: Monitoring and responding to system demand and capacity

- further develop analysis of demand and capacity to enable more sophisticated and long range forecasting

Change 3: Multi-disciplinary (MDT) working

- primary care involvement in the MDT for discharge planning

Change 4: Home first / discharge to assess

- ensure nursing capacity in the community to do complex assessments
- further develop reablement and rehabilitation offer in terms of response times and level of care

Change 5: Flexible working patterns

- review need and costs/ benefits of expanded 7 day working across more teams in trusts, providers and community health
- enable more care packages to start at weekends

Change 6: Trusted assessment

- ensure Trusted Assessor model is fully embedded

Change 7: Engagement and choice

- choice protocol to be further refined and updated to reflect instances where there is limited choice available

Change 8: Improved discharge to care homes

- enable more weekend discharges to care homes

Change 9: Housing and related services

- ensure expected dates of discharge incorporate housing related needs

Actions arising from the **100 day challenge** exercise undertaken by trusts to improve transfers of care will be incorporated into improvement plans.

The BCF will be aligned with **winter planning** for 2022/23, particularly in terms of the focus of resources on minimising delayed transfers of care. This will include consideration of projected **demand and capacity for intermediate care** (provisional analysis included in template with this BCF submission to be built upon).

Further development areas for 2022/23 to deliver admissions avoidance objectives

Population health and Core20PLUS5: It is a priority to identify capacity to develop the Core20PLUS5 approach in 2022/23, working with ICS analytics teams to identify key population groups to target improvements in heath inequalities. This is likely to compliment the current Vital 5 strategy which focuses on people with key risk factor for poor health outcomes. (See also section 8, health inequalities)

Same day emergency care: The developing same day emergency care strategy will make a significant contribution to the BCF target for the reduction in avoidable emergency admissions.

Anticipatory Care and neighbourhood model development: Anticipatory Care is an NHS Long Term Plan commitment that aims to provide proactive and personalised health and care for individuals living with multiple long-term conditions, delivered through multidisciplinary teams in local communities. It aims to reduce avoidable admissions and improve outcomes by intervening earlier, proactively, and more holistically, whilst the patient is at home. A national framework for local implementation is in development that is expected to be finalised during the period of this plan. Southwark has undertaken a baseline

assessment of its preparedness for the introduction of Anticipatory Care and will develop a more detailed implementation plan building on the strengths of its current neighbourhood model arrangements in response to the framework.

BCF metrics and targets 2022/23

As set out in the detailed finance and metrics BCF template there are 4 main targets for 2022/23 that reflect delivery of objectives:

Avoidable admissions to hospital (unplanned admissions for chronic ambulatory care sensitive conditions)

Southwark has a relatively high rate of avoidable admissions on this metric, with the main related conditions being COPD, congestive heart failure and asthma. Taking into account benchmark rates an aspiration to reduce this by 5% is proposed with key drivers for improvement including:

- Improved Primary Care Access
- Care co-ordination at a neighbourhood level aimed at people identified as being at risk of admission
- Promoting self-management of long term conditions (BCF funded self-management courses being reviewed and re-commissioned)
- Development of same day emergency care as alternative to admission

Discharge to usual place of residence

Southwark has a comparatively very high rate of 97% on this metric reflecting a strong home first approach. It is not considered appropriate to aim to increase this further as for some discharges there is potential scope to better meet people's needs by discharge to specialist step down beds.

Permanent admissions to care homes

The target set reflects an increase from 140 to 162 permanent admissions. This is a stretching target because based on last year's data, increased demand for services and increased acuity of need, the year-to-date data and high levels of growth in activity in the pre-admission pipeline, it is forecast that there will be a significant increase in 2022/23.

Effectiveness of re-ablement

The target proportion of people still at home 91 days after discharge from hospital into reablement services remains set at 83%. This is considered an optimal balance given levels of acuity of people entering the service.

6. Supporting unpaid carers.

Funding from the BCF for carers and Care Act duties

A total of £1.95m of BCF funding is targeted at carers and Care Act duties.

The BCF from its inception in 2015/16 has included an allocation of £1m from the NHS minimum contribution to the council to meet additional costs arising from the Care Act.

In addition, £400,000 is allocated to the local VCS (Southwark Carers) for the provision of respite and £450,000 for the costs of carers assessments and services. From 2021/22 an additional £100,000 of annual uplift was targeted at the identified priority area of supporting carers of people with dementia.

Services

There are currently estimated to be 25,700 carers in Southwark

The Voluntary Community Sector (VCS) support for carers, provides information and advice on carers rights, advocacy, accessing grants, legal advice, employment information and advice, accessing statutory services and contingency planning. Carers can access one to one emotional support, as well as enjoy a range of activities and groups, trips and outings, for wellbeing, social interaction and peer support.

Imago is a dedicated service for young carers, which provides emotional and practical support to young carers with caring responsibilities. Imago is funded from the council's general fund to support (currently) 223 young carers registered in Southwark, 53 of which have been supported through one to one activities (workshops, respite, etc) in the past year.

Both Imago and commissioned Voluntary Community Sector (VCS) providers delivery resources for professionals in health, education and social care to improve identification of "hidden" carers and to raise awareness of the impact of caring.

Southwark has commissioned ADASS Proud to Care online scheme to provide a wide range of discounts to paid and unpaid carers in Southwark amongst other boroughs. Southwark is able to add local businesses to the scheme. Unpaid carers receive assistance from the Voluntary Community Sector to access the scheme.

As of February 2022, carers and foster carers in Southwark have access to a 24 hour helpline which offers confidential, professional support and advice around; health and wellbeing, money worries, self-care and respite, consumer and legal issues, family and home, work and life.

Carer training

The Institute of Public Care has recently been selected to facilitate carer training for staff across ASC, Aging Well Southwark and Commissioning. The workshops, which will be co-produced with Carers and representatives from the voluntary sector. They will embed the ethos and approach established by the Carer Pathway project, developing staff to;

- Understand and overcome the challenges to carer identification.
- Have skilled strengths based conversations, supporting carers to access resources to sustain the caring relationship and their own wellbeing.
- Use a more creative and person centred approach to support planning and use of direct payments

7. Disabled Facilities Grant (DFG) and wider services

The DFG service is based within Southwark Council's Private Sector Housing & Adaptations Team and delivered through the Home Improvement Agency (HIA). It is funded by a ring-fenced grant paid to the council for the discharge of its statutory duties to administer a DFG scheme. The DFG supports people with disabilities who are owner-occupiers (who may be asset rich and cash poor) and tenants of private rented/housing association housing by funding physical adaptations to their homes that enable them to remain long term in their own home in the community, avoiding admissions to hospital and care homes. As well as major adaptations the DFG also funds a handyperson service which works closely with the hospital discharge teams to enable people to return home from hospital when their house needs minor repairs. Under the Regulatory Reform Order flexibilities Southwark also provide a range of small repairs grants and loans to help vulnerable people carry out repairs and improvements to their homes.

The Disabled Facilities Grant has a budget of £1.686m for 2022/23. This is the same allocation of funding as in 21/22, in real terms this can be seen to be a decrease in funding with the rise in costs of materials etc. Growth has been focussed on securing an increase in senior occupational therapist capacity to reduce delays and increase the number of people accessing DFG's.

In 22/23 the focus has been working on clearing the backlog of cases and dealing with any urgent / emergency cases. The financial means test for DFG applications continues to be temporarily waived. The overall delivery process has also been reviewed and improvements implemented. Financial counsellors continue to support applicants and provide assurance with safety etc.

Due to the high demand for grantss and the impact of the pandemic the HIA had to put in place a waiting list. There are currently 53 cases on the waiting list a reduction from 100 cases in 21/22. The team continues to work to reduce those on the waiting list.

From April 2022 to date, we have completed 35 major adaptations, of which 24 were for level access showers and 3 for stairlifts.

The DFG Service works with adult social care by having joint meetings bi-monthly to specifically discuss complex cases and every 3 months to discuss the progress of cases, staffing etc

Other specific areas of improvement:

- The DFG service is in the process of employing a Senior Occupational Therapist. This will help increase the number of OT assessments, improve communication/queries with adaptations on site and build stronger links with ASC and Health colleagues.
- The DFG service continues to work with a fast track system that has been put in place to ensure cases assessed as urgent or end of life are prioritised.
- The Housing team have been trained in falls prevention and provide advice, support and practical help when visiting older, frail and vulnerable people to help prevent the risk of falls and potential hospitalisation

The case studies below illustrate how DFGs can benefit service users:

Ms N (37) suffers with dispraxia, curvature of spine, knee and hip problems. Her condition impacted on her general wellbeing as she unable to do what she would like to and when. The Occupational Therapist (OT) recommended a level access shower for Ms N. The HIA Financial Counsellor completed the DFG Grant application, liaised with surveyor and contractor to see the OT recommendation to reality. Ms N was very appreciative for the adaptations as it has given her independence in showering, as it had been years in which she was able to use her bathroom. Ms N has children and so this has given her a new lease of life with her family.

Ms J (83) has arthritis and muscular degeneration which has made her very dependent on family members to care for her personal needs and independence. This was becoming a more challenging situation for Ms J. The OT recommended a level access shower and level flooring between all doors in the home. Ms J lives in a HA property and they did not have the funds to adapt their property for the tenant and so this was passed to the HIA to address. The HIA Financial contacted the Ms J's granddaughter and completed the grant application, requested for a surveyor and contractor to be appointed for Ms J case and the works were completed. Ms J's granddaughter reported that the works completed by the HIA have aided not just Ms J but the whole family as they do not have to worry about Ms J having slips and falls in the property and Ms J can shower independently improving her feel good factor.

Mrs C (61) lives in a HA property and lives with her husband. She suffers with parkinsons, anxiety and depression. With these conditions Mrs C was unable to use her bathroom. An OT recommended a LAS and the HIA Financial Counsellor coordinated the grant application process with Mrs C's nephew, surveyor and contractor. Mrs C's nephew reported that her circumstances were progressively getting worse due to her inability to use the bathroom. This was addressed through the assistance of the HIA and Mrs C's nephew stated "the works helped significantly, and have had a huge impact on her day to day life as she showers easily with no difficulties".

Wider joint working with housing, health and social care

The Partnership Southwark neighbourhood model identifies a wide range of statutory and voluntary services that have a role in helping people improve their outcomes. Housing is key within this - and is an especially important partner in Southwark given the high levels of social housing, particularly amongst older people.

Housing services are engaged in Partnership Southwark's population-based programmes where housing issues are relevant to a particular workstream/project and the Partnership Southwark programme team are a core member of the Housing and Social Care Partnership Board.

Specific examples of joint working include:

- The BCF provides additional resources to have a housing advice officer working within the hospital discharge teams with the objective of addressing housing related delays as effectively as possible. This has been a considerable success and rolled out as an example of good practice.

- There is a strong link between housing, adults social care and health with regards to the BCF funded telecare services which the Housing department provides. For example, the telecare service provides pendant alarms, enabling a response to people who have fallen to be provided that reduces avoidable ambulance call-outs. This includes the use of emergency lifting cushions where necessary to assist the faller.
- The ICES equipment issued also helps people live in their home with more minor adaptations (e.g. bath rails) that complement the major adaptions offer
- The ongoing development of joint commissioning arrangements for supported housing and supported living arrangements for adults with complex needs, and extra care facilities for older people as an alternative to care homes.
- Close working between the council and health on the refugee and asylum seekers agenda
- During the pandemic there were many examples of proactive integrated working between health, housing and social care which we wish to build on. For example, in relation to homeless hotels and the vaccination programme in hostels.

8. Equality and health inequalities

Supporting the Southwark Health and Wellbeing Strategy

The drive areas included in the refreshed Southwark Health and Wellbeing Strategy agreed by the Health and Wellbeing Board in July 2022 are set out below. These form a basis for tackling health inequalities in Southwark.

Drive 1: A whole-family approach to giving children the best start in life

Focused on ensuring families receive care that works for them during pregnancy and a child's first years, and good mental health support for the whole family

Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy

Focused on improving access to good quality jobs through our employment and procurement practices and helping working age adults to lead healthy lifestyles

Drive 3: Early identification and support to stay well

Focused on keeping people well as they age through prevention, early detection and intervention, and support for carers

Drive 4: Strong and connected communities

Focused on shaping services with communities, tackling isolation and ensuring services are accessible to all

Drive 5: Integration of Health and Social Care

Focused on joined-up, person-centred care, good governance and making the best use of the Southwark pound

The key areas in which the BCF will support the refreshed Health and Wellbeing Strategy are as follows:

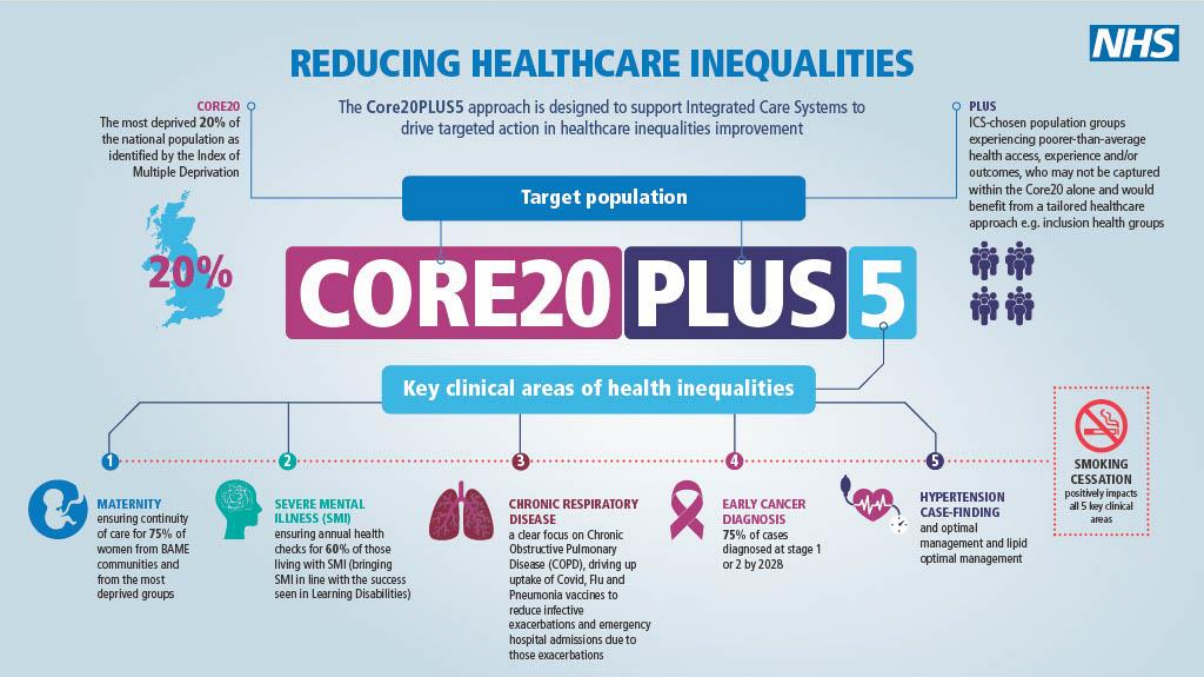
Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy: the BCF provides funding for costs associated with the Southwark ethical care charter, which helps ensure good employment practices in commissioned services.

Drive 3: Early identification and support to stay well: The BCF funds a number of services that have preventative value including the voluntary sector hub, falls prevention, self-management for people with long term conditions and telecare. Also captured under this heading is a range of core out of hospital services funded through the BCF such as rehab and reablement, carers support and hospital discharge support.

Drive 4: Strong and connected communities: BCF funding supports the voluntary sector hub which play a key role supporting strong communities. The vision for integration which the BCF supports includes the development of a strong neighbourhood model which would help promote community resilience.

Drive 5: Integration of Health and Social Care: The BCF is a key pooled budget providing a foundation for the alignment of resources as an enabler of integration. It funds services that have become more integrated e.g. Reablement and Community Health enhanced rapid response have integrated as Intermediate Care Southwark. The **Health and Care Plan** and an associated outcomes framework will be developed over 2022/23 to provide detail on the delivery of this drive area. The BCF will be fully aligned with this plan.

Core20PLUS5: As referenced in relation to reducing avoidable admissions, it is a priority to develop the Core20PLUS5 approach in 2022/23, working with NHS analytics teams and public health to identify key population groups to target improvements in heath inequalities. This is likely to compliment the current Vital 5 strategy which focuses on people with key risk factor for poor health outcomes. The Core20PLUS5 approach is illustrated in the diagram below:



Partnership Southwark Recovery Plan – focus on inequalities

The Partnership Southwark Recovery Plan sets out the wide range of inequalities in outcomes experienced by Southwark's population which were highlighted and exacerbated by the differential impact of COVID-19 on communities. Addressing inequalities is at the heart of the partnership's 4 key population-based programmes:

Addressing Inequalities actively listening and responding to partners and residents in support of Southwark Stands Together and in building broader community engagement			
Safeguarding our communities and those who support them mitigating and managing any second wave of COVID-19 with dedicated support to those who are vulnerable or at risk			
Start Well supporting children and young people - "keeping families strong"	**Live Well** supporting working age adults with joined up services that tackle the causes of ill-health and promote wellbeing	**Age Well** neighbourhood-based networks to keep people as healthy and independent as possible in their home	**Care Well** supporting those in care and residential settings for older people and physical disabilities, mental health and learning disabilities

The BCF funding is a key enabler of the adult's focused live well, age well and care well workstreams, funding a significant range of community based health and care services that are working together to deliver the objectives of the plan.

The Partnership is committed to a data driven population health approach to addressing inequalities. It draws on intelligence and recommendations from the Covid 19 JSNA and the guiding principles of the health inequalities framework both of which have been shaped and informed by a range of stakeholders from within the partnership.

Contribution to Equalities Act requirements

The BCF funds services that provide a range of essential personalised support for people with health and social care needs. This has important benefits for people with protected characteristics under the Equalities Act, many of whom are reliant on these services, in particular older people, people with disabilities and people with mental health problems. Other beneficiaries of BCF investment are the homecare workforce who have been paid the London living wage since April 2018 as a result of BCF investment in our ethical home care policy. This workforce is mainly made up of women and those from the black and minority ethnic communities.

Example of BCF funded services contributing to equalities aims: Behavioural Support

The Behavioural Support scheme has been funded in 2022/23 for £100k. This scheme supports younger people with learning disabilities and challenging behaviour to remain in the community through the provision of enhanced psychological support, avoiding placement breakdown and the need to enter more restrictive placements including secure inpatient settings. This is a group with poor health and wellbeing outcomes that the BCF scheme will help address by enabling a more preventative "all ages" approach.

The London Borough of Southwark Positive Behaviour Service (LBS PBS) has an operational policy with pre/post intervention survey.

A Clinical Psychologist has been recruited by LBS that will support the LBS PBS offer and deliver preventative interventions with the team. The PBS team (2 x PBS workers funded by the £100k BCF money and a Clinical Psychologist - funded by LBS) are supporting Complex cases. These are AAD clients who are at risk of placement breakdown/hospital admission.

The Dynamic Support Register (DSR) will be utilised to accurately log Southwark clients escalation as well as de-escalation (red, amber, green). This will underpin the outcome measurements and help determine the effectiveness of the service.

Annex 1 – full summary of BCF changes 2021/22 to 2022/23

Better Care Fund - 2022 -2023

Description	Final Annual Plan 21-22 £	Additional contributions/changes £	Uplift 2022/23 £	Draft Plan 2022/23 £
Local Authority				
Community Support				
Dementia - Enhanced Neighbourhood Support	184,177			184,177
Homecare Quality Improvement	1,900,000			1,900,000
Residential & Nursing	1,871,339			1,871,339
Protect Adult Social Care - Residential Care	2,010,610			2,010,610
Reablement & Nursing Support Pressures	0	0	263,000	263,000
Total Community Support	**5,966,126**	**0**	**263,000**	**6,229,126**
Hospital Discharge				
Contingency - council staff	300,000			300,000
Discharge to Assess - Council Costs	260,000		250,000	510,000
Reablement - OT Team	0		455,885	455,885
Hospital discharge	1,790,453			1,790,453
Housing Worker Discharge Team	50,000			50,000
Intermediate Care	1,137,563			1,137,563
Night Owls - overnight intensive homecare	224,000			224,000
Reablement	1,936,738			1,936,738
Total Hospital Discharge	**5,698,754**	**0**	**705,885**	**6,404,639**
Mental Health & Wellbeing				
Community Mental Health Services	655,000			655,000
Enhanced Psychological Support for those with LD	29,000			29,000
Learning Disability - Personal Budgets	211,000			211,000
Mental Health Reablement	151,632			151,632
Mental Health - Personal Budgets	600,000			600,000
Mental Health Broker	60,000			60,000
Mental Health Complex Cases Worker	50,000			50,000
Mental Health Discharge Worker	50,000			50,000
Psychiatric Liaison (AMHPs and reablement)	300,000			300,000
Total Mental Health & Wellbeing	**2,106,632**	**0**	**0**	**2,106,632**
Misc				
Care Act Funding	1,000,000			1,000,000
Service Development and Change Management	45,000			45,000
Total Misc	1,045,000	0	0	1,045,000
Prevention				
Carers Strategy	450,000			450,000
Unpaid Carers	100,000			100,000
Community Equipment	562,000	246,850		808,850
Telecare	566,000	444,626	57,995	1,068,621
Voluntary Sector Prevention Services	1,248,251	482,749		1,731,000
Voluntory Sector Carers work	400,000	113,000		513,000
Total Prevention	**3,326,251**	**1,287,225**	**57,995**	**4,671,471**
London Borough of Southwark	**18,142,763**	**1,287,225**	**1,026,880**	**20,456,868**
South East London CCG - Southwark				
Mental health and Learning Difficulty				
Enhanced Intervention Service	218,403		5,962	224,365
Total Mental health and Learning Difficulty	**218,403**	**0**	**5,962**	**224,365**
Admission Avoidance				
Admissions avoidance - ERR and @home	4,644,157		78,951	4,723,108
GP Support @ Home Acuity	0	0	253,500	253,500
@Home Geriatric Assessment	0	0	30,000	30,000
@Home Integrated Care Fellows		82,500		82,500
@ Home Nursing Expansion		108,788		108,788
Falls Service - Expansion of BCF		820,832		820,832
Care home pharmacist	47,095	-47,095		0
Enhanced primary care access	743,000	-743,000		0
Self-management	327,347	-110,140		217,207
Total Admission Avoidance	**5,761,599**	**111,885**	**362,451**	**6,235,935**
Hospital Discharge				
Neuro-rehab team - GSTT	193,728		3,293	197,022
Total Hospital Discharge	**193,728**	**0**	**3,293**	**197,022**
Prevention				
ICES	420,518	1,200,520	25,909	1,646,947
Behavioural Support LD & Autism	100,000			100,000
Total Prevention	**520,518**	**1,200,520**	**25,909**	**1,746,947**
Service Development				
Service development (50% CCG element)	330,758			330,758
Total Service Development	**330,758**	**0**	**0**	**330,758**
SEL CCG - Southwark	**7,025,006**	**1,312,405**	**397,615**	**8,735,026**
Total Better Care Fund - CCG contribution & additional funds	**25,167,769**	**2,599,630**	**1,424,495**	**29,191,895**
Other Local Authority				
Disabilities Facilities Grant	1,686,144			1,686,144
IBCF*	17,322,581		524,768	17,847,349
Total Other - Local Authority	**19,008,725**	**-**	**524,768**	**19,533,493**
Total Better Care Fund	**44,176,494**	**2,599,630**	**1,949,263**	**48,725,388**

Annex 1 cont.

*The full use of the IBCF grant is now as set out below;

IBCF Grant 2022/23 (Council)

Home Care	£11,198,498
Nursing Care	£4,474,334
Reablement and Intermediate bed based care	£999,749
Residential care for older people	£400,000
Transformation Fund	£250,000
IBCF Flexicare (22/23 growth)	£524,768
Total IBCF	**£17,847,349**

BCF Planning Template 2022-23

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

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, 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'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

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).

4. Income (click to go to sheet)

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 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. 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.

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

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, 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 Conditions 2 and 3 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 5b.
- 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. 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 National Condition 2.
- 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.

6. 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 under National Condition 3. 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.

7. 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.

8. 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.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

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 2022-23. 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 2022-23.

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 2022-23. 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 (2020)
- Actual performance for each quarter of 2021-22 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.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- 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. 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 2021-22, 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 2022-23 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 2021-22 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.

3. Residential Admissions (RES) planning:
- 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 2021-22. 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.

4. Reablement planning:
- 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 2021-22. 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.

7. Planning Requirements (click to go to sheet)

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 Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 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 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	Southwark
Completed by:	Adrian Ward
E-mail:	adrian.ward@selondonics.nhs.uk
Contact number:	0208 176 5349
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	
If using a delegated authority, please state who is signing off the BCF plan:	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	n/a
Name:	n/a

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Kieron	Williams	kieron.williams@southwark.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Andrew	Bland	andrew.bland@selondonics.nhs.uk
	Additional ICB(s) contacts if relevant		Martin	Wilkinson	martin.wilkinson@selondonics.nhs.uk
	Local Authority Chief Executive		Althea	Loderick	althea.loderick@southwark.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		David	Quirke-Thornton	david.quirke-thornton@southwark.gov.
	Better Care Fund Lead Official		Adrian	Ward	adrian.ward@selondonics.nhs.uk
	LA Section 151 Officer		Duncan	Whitfield	duncan.whitfield@southwark.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. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Southwark

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£26,590,914	£26,590,914	£0
iBCF	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£0
Additional ICB Contribution	£1,309,308	£1,309,308	£0
Total	**£48,720,940**	**£48,720,940**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£7,556,384
Planned spend	£7,719,874

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£18,463,196
Planned spend	£19,140,643

Scheme Types

Assistive Technologies and Equipment	£3,524,418	(7.2%)
Care Act Implementation Related Duties	£1,000,000	(2.1%)
Carers Services	£1,063,000	(2.2%)
Community Based Schemes	£12,554,205	(25.8%)
DFG Related Schemes	£1,686,144	(3.5%)
Enablers for Integration	£371,047	(0.8%)
High Impact Change Model for Managing Transfer of C	£2,810,453	(5.8%)
Home Care or Domiciliary Care	£13,322,498	(27.3%)
Housing Related Schemes	£524,768	(1.1%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£348,654	(0.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£811,000	(1.7%)
Prevention / Early Intervention	£1,948,470	(4.0%)
Residential Placements	£8,756,283	(18.0%)
Other	£0	(0.0%)
Total	**£48,720,940**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0	0.0

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	96.7%	96.9%	97.0%	97.1%

Residential Admissions

		2020-21 Actual	2022-23 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	476	539

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	83.0%

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 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Southwark

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Southwark	£1,686,144
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,686,144**

iBCF Contribution	Contribution
Southwark	£17,847,349
Total iBCF Contribution	**£17,847,349**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Southwark	£1,287,225	consolidating related non BCF budgets, VCS,
Total Additional Local Authority Contribution	**£1,287,225**	

NHS Minimum Contribution	Contribution
NHS South East London ICB	£26,590,914
Total NHS Minimum Contribution	**£26,590,914**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS South East London ICB	£1,309,308	transfer of related non-BCF budget
Total Additional NHS Contribution	**£1,309,308**	
Total NHS Contribution	**£27,900,222**	

	2021-22
Total BCF Pooled Budget	**£48,720,940**

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

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Southwark

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£26,590,914	£26,590,914	£0
iBCF	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£0
Additional NHS Contribution	£1,309,308	£1,309,308	£0
Total	**£48,720,940**	**£48,720,940**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,556,384	£7,719,874	£0
Adult Social Care services spend from the minimum ICB allocations	£18,463,196	£19,140,643	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Hospital Discharge	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,790,453	Existing
2	Reablement	Intermediate Care Services. Includes OT team 22.23 £456k	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Private Sector	Minimum NHS Contribution	£2,655,623	Existing
3	Discharge to assess	HICM for Managing Transfer of Care - inc 22.23 £250k growth	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum NHS Contribution	£510,000	Existing
4	Nightowls - overnight homecare	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		Joint	50.0%	50.0%	Private Sector	Minimum NHS Contribution	£224,000	Existing
5	Housing Worker - Discharge Team	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£50,000	Existing
6	Council assessment and care management	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£300,000	Existing
7	Intermediate care supported discharge	Intermediate Care Services	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,137,563	Existing

8	Home care quality	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,900,000	Existing
9	Carers (Southwark carers)	Carers Services	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£400,000	Existing
10	Carers (assessment)	Carers Services	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£450,000	Existing
11	Telecare	Assistive Technologies and Equipment inc 22.23 growth £57,995	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum NHS Contribution	£623,995	Existing
12	Community Equipment (Council main	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum NHS Contribution	£562,000	Existing
13	Mental health reablement	Community Based Schemes	Reablement in a persons own home	Preventing admissions to acute setting		Social Care		LA			Local Authority	Minimum NHS Contribution	£151,632	Existing
14	Community Mental Health Services	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum NHS Contribution	£655,000	Existing
15	Mental health placement broker	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£50,000	Existing
16	Mental health Complex Cases worker	Community Based Schemes	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£60,000	Existing
17	Psychiatric liason	Community Based Schemes, admissions avoidance	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	Minimum NHS Contribution	£300,000	Existing
18	Mental health Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£600,000	Existing
19	Learning disability Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Physical health/wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£211,000	Existing
20	Service development	Enablers for Integration	Enablers for Integration	Programme management		Social Care		LA			Local Authority	Minimum NHS Contribution	£45,000	Existing
21	Unpaid Carers	Support for carers of people with dementia	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum NHS Contribution	£100,000	Existing
22	Residential & Nursing	Residential Placements inc 22.23 growth £263k	Residential Placements	Nursing home		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,871,339	Existing
23	Dementia navigators	Integrated Care Planning and Navigation	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£184,177	Existing
24	Placement costs (Protecting social care)	Residential Placements	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum NHS Contribution	£2,010,610	Existing
25	Care Act Funding	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,000,000	Existing

26	Voluntary Sector Hub	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing		Social Care		Joint	28.0%	72.0%	Charity / Voluntary Sector	Minimum NHS Contribution	£1,248,251	Existing
27	Mental Health Discharge Social Work staff	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£50,000	Existing
28	iBCF funding plans - home care	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£10,327,850	Existing
29	iBCF funding plans - nursing care homes	Residential Placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£4,174,334	Existing
30	iBCF funding plans - Transformation fund to improve	Community Based Schemes	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	iBCF	£250,000	Existing
31	IBCF Reablement and Intermediate bed based care	Intermediate Care Services	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	iBCF	£999,749	Existing
32	Residential care for older people	Residential Placements	Residential Placements	Care home		Social Care		LA			Charity / Voluntary Sector	iBCF	£400,000	Existing
33	Nursing Care for older People	Residential Placements	Residential Placements	Nursing home		Social Care		LA			Private Sector	iBCF	£300,000	Existing
34	Home care for older people	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£870,648	Existing
35	Disabled Facilities Grants	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£1,686,144	Existing
36	Admissions avoidance - ERR and @home	Community health services enhanced rapid response and @home	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£5,006,608	Existing
37	Self-management (adjusted 22.23)	Self-management for people with long term conditions.	Prevention / Early Intervention	Social Prescribing		Primary Care		CCG			Charity / Voluntary Sector	Minimum NHS Contribution	£217,470	Existing
38	Neuro-rehab team	Support workers for GSTT community neuro-rehab team	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£197,022	Existing
39	Service development	Funding for the Partnership Commissioning team,	Enablers for Integration	Joint commissioning infrastructure		Community Health		Joint	50.0%	50.0%	CCG	Minimum NHS Contribution	£326,047	Existing
40	Enhanced Intervention Services	MDT providing enhanced psycholgical support for people with learning	Community Based Schemes	Integrated neighbourhood services		Mental Health		Joint	88.6%	11.4%	NHS Mental Health Provider	Minimum NHS Contribution	£253,365	Existing
41	Community Equipment Service	ICES Contract - CCG costs -	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Private Sector	Minimum NHS Contribution	£446,427	Existing
42	Behavioural Support LD & Autism	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Mental Health Provider	Minimum NHS Contribution	£100,000	Existing
43	Community Equipment Service -additional cont	ICES Contract - CCG costs - additional BCF cont 22.23	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Private Sector	Additional NHS Contribution	£1,200,520	New

44	@ home integrated care fellows	@ home additional BCF contribution 22.23	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£82,500	New
45	@home nursing support	@ home additional BCF contribution 22.23	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Additional NHS Contribution	£108,788	New
46	Falls service	Community health services additioanl contribution 22.23	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£820,832	New
47	VS preventative	Voluntary sector budgets additional contribution 22.23	Prevention / Early Intervention	Social Prescribing		Social Care		CCG			Charity / Voluntary Sector	Additional LA Contribution	£482,749	New
48	VC Carers	Voluntary sector budgets additional contribution 22.23	Carers Services	Respite services		Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£113,000	New
49	Telecare	Telecare budgets additional contribution 22.23	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Additional LA Contribution	£444,626	New
50	ICES council additional contribution 22.23	ICES budgets additional contribution 22.23	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Additional LA Contribution	£246,850	New
51	IBCF Flexicare (22.23 growth)	care element housing based schemes	Housing Related Schemes			Social Care		LA			Private Sector	iBCF	£524,768	New

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

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'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. 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. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. 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 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. 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 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 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) 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 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 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. 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 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. 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. 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 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 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 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. 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 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 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. 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. 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	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. 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. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 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.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 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.

16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 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	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.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Southwark

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	Checklist Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	242.9	226.3	262.6	215.8	Benchmarking data shows that Southwark is top quartile for London. Although further analysis is required at admission type level to understand the extent to which they can be reduced, a target to reduce by 5% is considered appropriate.	The population health management approach will continue to focus on identifying those at risk of admission. Core20PLUS5 approach to be developed alongside Vital 5. To ensure that the case finding approach identifies and responds effectively to the top 4 admission types in this measure: COPD, Congestive Heart Failure, Diabetes and Asthma.	
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
	Indicator value	231	214	249	205			Yes

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

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	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 (SUS data - available on the Better Care Exchange)	Quarter (%)	96.7%	96.9%	97.0%	97.1%	2021/22 benchmarking data shows Southwark had highest performance in London & 4th highest nationally. A target for a higher rate would potentially not allow for sufficient use of specialised step down accommodation including for discharge to assess, or care home placement when required. Hence target is to maintain current performance.	Maintain strength of current discharge support arrangements to retain current high rate of performance.	Yes
	Numerator	5,094	5,182	5,104	5,098			
	Denominator	5,266	5,346	5,263	5,252			
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
	Quarter (%)	96.7%	96.9%	97.0%	97.1%			
	Numerator	5,094	5,182	5,104	5,098			Yes
	Denominator	5,266	5,346	5,263	5,252			Yes

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
	Annual Rate	476.1	655.7	483.2	538.8	This area of provision is in flux due to unpredictable demand as a result of rapid hospital discharges, and the remodelling of D2A. A significant increase in care home	A range of services support people to live in their own home and avoid or delay the need for care home admission, as set out in the BCF narrative plan. Includes	Yes
	Numerator	133	190	140	162			Yes

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Denominator	27,938	28,976	28,976	30,064	demand is forecast for 2022/23 based on year-to-date data, increased demand for services and increased acuity of need, combined with growth in activity in the pre-admission pipeline. In this context the target is stretching as actual growth would be much higher without the initiatives in the BCF plan. Target reflects the mode figure taken from the last five years of SALT data submissions.	reablement, intermediate care, home care, extra care / flexi care, ICES and telecare, community health, home first discharge to assess.	

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

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 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 (%)	82.0%	82.0%	83.3%	83.0%	The plan is based on 2 years activity data and takes into account anticipated increases in referrals & needs levels that make achieving a higher rate on this measure difficult. We consider the current rate of 83% is at the right level and is a stretching target.	The delivery of this target will be supported by the extended pathway work of D2A, alongside the interventions of re-enablement and UCR to keep people in their own home.	Yes
	Numerator	219	482	666	760			Yes
	Denominator	267	588	800	916			Yes

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

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Southwark

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement 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	Checklist Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? 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? 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?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes				Yes
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • 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 - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. 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.	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes				Yes
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes				Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes				Yes
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes				Yes

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans,

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
quarters of 2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care

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 grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, cont
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

england.bettercarefundteam@nhs.net

(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via

3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
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 uses the pathways set out in the https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and
Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet 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

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet 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:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

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
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest level 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

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. 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 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)

- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

HM Government

NHS

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Southwark
Completed by:	Adrian Ward
E-mail:	adrian.ward@selondonics.nhs.uk
Contact number:	0208 176 5349
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 report is expected to be signed off:	

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	n/a
Name:	n/a

How could this template be improved?	Data items required should in future be incoprorated into existing community services and social care data sets.

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Southwark

3. Demand

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 uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider 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 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	861	794	794	834	774	804
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	91	93	93	98	92	95
2: Step down beds (D2A pathway 2)	17	17	17	19	18	19
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	36	32	32	33	30	30

Any assumptions made:	For purposes of consistency this data is derived from the ICB 2022/23 Operating Plan trajectories data for discharges broken down for Pathways 0 to 3 disaggregated by borough and trust as set out in guidance. This does not align exactly to the sub-headings above. Hence for example this shows all Pathway 0 discharges, but not all of these receive low level support.

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

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	422	389	389	409	379	394
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		405	373	373	392	364	378
OTHER		34	32	32	33	31	32
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	40	45	45	48	45	46
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		47	44	44	46	43	45

OTHER		4	4	4	4	4	4
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	2: Step down beds (D2A pathway 2)	8	8	8	9	9	9
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		8	8	8	9	8	9
OTHER		1	1	1	1	1	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	18	16	16	16	15	15
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		17	15	15	16	14	14
OTHER		1	1	1	1	1	1

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Southwark

3.2 Demand - Community

This worksheet 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 (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	The VCS provide a range of low level support services following community referral but these do not meet the definition of intermediate care. Demand forecast based on 12 months historic data. Av monthly community referrals accepted for reablement 40, for intermediate care comm health 24, @home 38. Bed based intermediate care mostly via discharge from hospital. Note does not include estimates of unmet demand.

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	0	0	0	0	0	0
Urgent community response	120	120	120	120	120	120
Reablement/support someone to remain at home	102	102	102	102	102	102
Bed based intermediate care (Step up)	0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Southwark

4.2 Capacity - community

This sheet 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 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

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.

Any assumptions made:	VCS excluded as not defined as Intermediate Care. Capacity figures assume no significant change in current capacity reflected in the demand figures. Bed based step up minimal.

Capacity - Community							
Service Area	**Metric**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	0	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	120	120	120	120	120	120
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	102	102	102	102	102	102
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Southwark

4.1 Capacity - discharge

This sheet 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:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

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.

Any assumptions made:	Capacity figures assume no significant change in current capacity. Note VCS low level support not Intermediate Care, estimated at 5% of discharges. Reablement 31 per month, Int Care 34, @home 81 based on demand over last year. Residential care based on actual planned permanent admissions to residential and nursing care. Pulross rehab average 2 int care admissions per month. Step down beds does not include D2A beds as not Intermediate Care.

Capacity - Hospital Discharge							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	45	41	41	43	40	41
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	77	77	77	77	77	77
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	146	146	146	146	146	146
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	2	2	2	2	2	2
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	15	15	15	15	15	15

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board:	Southwark

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£11,622,419
BCF related spend	£10,135,065

Comments if applicable	Healthcare expenditure relates to Intermediate Care Services within our Guys & St Thomas NHS FT contract. Overall spend is split approx 50:50 between council and ICB

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HEALTH AND WELLBEING BOARD AGENDA DISTRIBUTION LIST (OPEN)
MUNICIPAL YEAR 2022/23

NOTE: Amendments/queries to Maria Lugangira, Constitutional Team, MSTeams

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		Dated: September 2022	