Open Agenda

Extraordinary Health and Wellbeing Board

Thursday 3 August 2023
11.00 am
160 Tooley Street, London SE1 2QH / HYBRID

Membership

Councillor Kieron Williams (Chair)	Leader of the Council
Dr Nancy Kuchemann (Vice-Chair)	Co-Chair Partnership Southwark and Joint Chair of the Clinical and Care Professional Leadership Group
Councillor Evelyn Akoto	Cabinet Member for Health and Wellbeing
Councillor Jasmine Ali	Deputy Leader and Cabinet Member for Children, Education and Refugees
Councillor Maria Linforth-Hall	Opposition Spokesperson for Health
Anood Al-Samerai	Chair, 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
Anna Garrod	Guy's and St. Thomas' Foundation, Director of Policy and Influencing
Clive Kay	Chief Executive, King's College Hospital NHS Foundation Trust
Sangeeta Leahy	Director of Public Health , Southwark
Althea Loderick	Chief Executive, Southwark Council
James Lowell	Place Executive Lead
Sheona St Hilaire	Chair, Healthwatch Southwark
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Alasdair Smith	Director of Children and Families
Martin Wilkinson	Chief Operating Officer, Southwark, NHS SEL Integrated Care Board

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information

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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: 26 July 2023

PRINTED ON RECYCLED PAPER

Extraordinary Health and Wellbeing Board

Thursday 3 August 2023
11.00 am
160 Tooley Street, London SE1 2QH / HYBRID

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.	**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. The deadline for receipt of public question is midnight Friday 28 July.	
7.	**BETTER CARE FUND 2023/24 - 2024/25**	1 - 79
8.	**ANY OTHER BUSINESS**	

Date: 26 July 2023

Agenda Item 7

Item No. 7	Classification: Open	Date: 3 August 2023	Meeting Name: Health and Wellbeing Board
Report title:		Better Care Fund 2023/24 – 2024/25	
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 agree to the 2023/24 - 2024/25 Better Care Fund (BCF) planning templates (appendices 1 and 2).

2. That the Health and Wellbeing Board agree the BCF 2022/23 year end return submitted to NHSE (appendix 3).

BACKGROUND INFORMATION

Note: this report was discussed at the Health and Wellbeing Board on 20/07/2023 and agreed in principle. Unfortunately, it was not possible to formally agree the report as the meeting was held on a hybrid basis and was not technically quorate for decision making purposes, as only members who are physically present can vote on or take decisions on items and less than 5 members were physically present.

The report is unchanged from the previous meeting apart from minor updates to appendix 2 on two issues to reflect feedback received from the national assurance process: Firstly, on the expenditure template we were asked to allocate a contingency for the 2024/25 Additional Discharge Fund, which has now been dispersed across existing schemes (but will still be subject to mid-plan review). Secondly, on the metrics template we were asked to expand on our rationale for the re-ablement target.Both changes have been accepted by the assurers and we have been advised that no further queries are expected.

3. 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 local NHS commissioners 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.

4. At its meeting on 30th January 2023 the board received an update on the BCF, including details of the £2.56m Adults Social Care Discharge Fund that had been added to the 2022/23 fund by government in December. The report also updated the board on discussions relating to the BCF strategy for 2023/24, including the option of expanding the BCF on a voluntary basis. It was also noted that pending the formal details of the national 2023/24 planning process there had been in principle agreement to roll forward 2022/23 budgets.

5. The 2023/24 – 2024/25 BCF Policy Framework and planning guidance was issued on April 4th and required submission of a BCF plan meeting the requirements by 28th June 2023. The completed planning templates (appendices 1 and 2) have been agreed through the BCF Planning Group and the respective governance processes of the council and the ICB. They have been submitted on a provisional basis to NHSE, subject to agreement by this Health and Wellbeing Board meeting. This governance route was agreed with the chair as preferable to the alternative of holding an extraordinary board meeting in June or delegating agreement to the chair or other members of the board.

6. It is also a requirement that the BCF year-end report is agreed by the Health and Wellbeing Board. This is attached for 2022/23 in appendix 3.

KEY ISSUES FOR CONSIDERATION

2023/24 to 2024/25 BCF

7. 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).

8. The current BCF is a two year plan, which provides welcome stability in planning terms compared to previous 12 month planning rounds. However, there will be a mid-term refresh of plans before 2024/25 plans are finalised and targets set. Any material changes will be reported to the board in line with BCF governance requirements.

9. The total value of the BCF is £54.2m in 2023/24 and £58.8m in 2024/25, within which the Additional Discharge Fund, ringfenced for supporting transfers of care from hospital, is £3.9m and £7.2m respectively.

10. The plan describes the approach to delivering the twin BCF goals to:

    - **Enable people to stay well, safe and independent at home for longer** (focussing on hospital and care home admissions avoidance)

    - **Provide the right care in the right place at the right time** (focussing on transfers of care from hospital)

11. Key points to note from the templates include:

    - The majority of the budgets and schemes agreed for 2023/24 relate to core community based health and social care services that it has been agreed will roll forward from 2022/23.
    - The Additional Discharge Fund in 2023/24 rolls forward a number of the Q4 schemes from the 2022/23 Adult Social Care Discharge Fund.
    - Further budget changes, including the use of annual growth, savings and the incorporation of service budgets into the BCF are set out on page 7 of appendix 1. This includes a reduction of £109,000 in the ICB additional contribution relating to the @home nursing budget which has been transferred to the core BCF @home budget.
    - The ICB minimum contribution to the core BCF increased by 5.66% (£1.5m).
    - The plan contains 5 key metrics and targets as set out in the template, including a new target on admissions to hospital due to falls and existing targets on avoidable admissions (Ambulatory Care Sensitive admissions), discharge to normal place of residence, care home admissions and reablement. A new target on delayed transfers of care from hospital is expected to be announced later in the year.
    - The plan includes a capacity and demand analysis relating to intermediate care for step down support from hospital and referrals from community settings to prevent avoidable admissions. This will be further developed during 2023/24 as the issues with our integrated community data set are resolved.

BCF Year-end Report 2022/23 (appendix 3)

12. The 2022/23 year-end report was submitted to NHSE in May following authorisation by the council and ICB. It is a requirement that it is presented to the Health and Wellbeing Board. The report sets out confirmation that national BCF conditions were met, BCF targets were delivered and expenditure was in line with the submitted plan. It also identifies areas of successes and challenges. In addition, it provides detailed information on the application of the Adult Social Care Discharge Fund.

Policy framework implications

13. 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 2023 to 2025 on 4th April 2023. The government issued the document "BCF Planning Requirements 2023/25" 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 draft Health and Care Plan and is consistent with the national framework.

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

Community impact statement

14. The BCF plan provides funding for 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.

15. 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 people from the black and minority ethnic communities. This principle is being expanded in the current plan to care home staff through additional funding for the Residential Care Charter.

Equalities (including socio-economic) impact statement

16. The narrative plan sets out how the BCF plan contributes to the equalities and health inequalities objectives of the draft Health and Care Plan and the Health and Wellbeing Strategy (see page 30).

Health impact statement

17. 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 health or care services. Page 30 of the plan sets out how the BCF aligns to the delivery of the Health and Wellbeing Strategy.

Climate change implications

18. As set out in page 33 of the narrative template the BCF plan will be delivered in line with the Partnership Southwark policy statement on environmental sustainability which incorporates the green policies of partnership organisations.

Resource implications

19. The financial template sets out a detailed schedule of the BCF budgets for 2023/24 to 2024/25 summarised in the table below.

SELICB - Better Care Fund Summary 2023-24 & 2024-25

Better Care Fund	2023/24 £'000	2024/25 £'000
Local Authority Better Care Fund - Core Contribution	20,255	21,401
SELICB Better Care Fund - Core Contribution	7,841	8,285
Local Authority - IBCF	17,847	17,847
Local Authority - DFG	1,686	1,686
Total Better Care Fund - Core	47,629	49,220
Local Authority Additional Contribution	1,287	1,287
SELICB Additional Contribution	1,201	1,201
Total Better Care Fund - Additional Contribution	2,488	2,488
Total Better Care Fund	**50,117**	**51,707**
Local Authority Hospital Discharge Contribution	2,502	4,154
SELICB Hospital Discharge Contribution	1,599	2,971
Total Hospital Discharge Contribution	4,101	7,125
Total Better Care Fund	**54,218**	**58,832**

Consultation

20. 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 (20AS2023-24)

21. The Strategic Director of Finance notes the recommendations of this report and the 2022-23 year end position detailed in Appendix 3. The Strategic Director of Finance also notes the provisional 2023-25 BCF plan highlighted in Appendix 2 which provides a comprehensive breakdown of how funds will be allocated alongside the expected outputs for the two financial years.

22. The pooled budget and income streams now represent a significant proportion of the partnerships core funding, in which the Better Care Fund, Improved Better Care Fund and the Discharge Fund contributes in excess of £40m of the council’s Adult Social Care budget. Therefore, it is important for officers to ensure expenditure is in line with the allocated plan and monitored and reported through the respective governance pathways.

23. The Strategic Director of Finance welcomes the newly introduced two year planning template and guidance which provides additional clarity and financial

confidence into the budget setting process. Given the financial turbulence present in the system, a longer term view on budget planning is encouraged in future years.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	BCF 2023/24 to 2024/25 Narrative Plan Template
Appendix 2	BCF 2023/24 to 2024/25 Finance and Metrics Template
Appendix 3	BCF 2022/23 Year End template

AUDIT TRAIL

Lead Officer	Martin Wilkinson, Chief Operating Officer, Southwark, NHS SEL Integrated Care Board Genette Laws, Director of Commissioning, Children and Adults, Southwark Council
Report Author	Adrian Ward, Head of Place PMO (Southwark), NHS South East London Integrated Care Board
Version	Final
Dated	26/07/23
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Assistant Chief Executive – Governance & Assurance	N/A	N/A
Strategic Director of Finance		Yes
Cabinet Member	No	No
Date final report sent to Constitutional Team		26 July 2023

HM Government

NHS England

BCF narrative plan template

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

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

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

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

Integration and Better Care Fund

Cover

Health and Wellbeing Board(s):

Southwark

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

Partnership Southwark members including South East London Integrated Care Board, Southwark Council (Public Health, Children and Adult Services, Housing), VCSE representatives, South London and Maudsley NHS FT, King's College Hospital NHS FT, Guys and St Thomas's NHS FT

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 and the SELICB Forward View

Governance

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

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 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 and Adults and the ICB's Chief Operating Officer for Southwark on behalf of the Place Executive Lead as well as Finance leads.

The BCF Planning Group is a sub-group of the Joint Commissioning Oversight Group which oversees health, public health, adults and children's social care joint commissioning arrangements.

Governance Arrangements for the Southwark BCF (Schematic)

* Partnership Southwark helps shape the future strategic direction of the BCF as part of the delegation of ICB governance to local care partnerships. It also oversees the Live Well, Age Well and Care Well programmes to which the BCF is aligned.

There are also overlaps with other programme governance arrangements in SEL ICB such as the Urgent and Emergency Care Board that oversees the new ICS discharge improvement plan and winter planning.

1. Executive Summary

This should include:

• Priorities for 2023-25

• Key changes since previous BCF plan.

Background to the BCF

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 2023/24 is £54.2m, including £2.5m additional funding above the minimum required level. The current plan also covers 2024/25 for which the expected budget is £58.8m. The delivery of the pooled budget is underpinned by the associated Better Care Fund plan which sets out how an integrated approach to the delivery of services will secure improved outcomes in line with local and national priorities.

Priorities for 2023/25

The local priorities of the Southwark BCF align strongly to the national statement of the BCF vision and objectives, which are set out as conditions in the 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**

This will help deliver the twin goals of **preventing avoidable admissions to hospitals and care homes** and **supporting safe, timely and effective transfers of care from hospital**.

In addition, achieving these objectives will support the delivery of population health and wellbeing outcomes and help tackle health inequalities as set out in our partnership plans by targeting resources at those most in need of support.

This plan sets out how these objectives will be achieved through the BCF in Southwark.

Local priorities and plans aligned with the BCF

The BCF plan is a key enabler for the delivery of a number of local partnership plans that are closely related, including:

- **The Southwark Health and Wellbeing strategy** – including priorities relating to early identification to stay well and the integration of health and social care
- **The draft Partnership Southwark Health and Care Plan** – including priorities relating to Age Well and Care Well, mental health, integration, collaborative working and neighbourhood working
- **The ICB Joint Forward View –** including priorities relating to strategic system wide collaboration
- **The ICS Integration Strategy –** priorities relating promoting health and well-being, and support for people with long term conditions
- **The ICB Operational Plan –** including its focus on recovery of NHS urgent and emergency services

Key focus areas for 2023/24

As set out in this plan there are a number of areas for development in 2023/24 including:

- Delivery of the South East London ICS Improvement Plan for physical and mental health transfers of care including the development of 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 and support recovery of planned and urgent care services
- Securing data improvements to support capacity and demand planning
- Additional Discharge Funding arrangements to be fully incorporated into BCF and deliver maximum impact on delays
- Development of step down options including facilities to reduce delayed transfers for pathway 2 and 3
- Development of a refreshed Market Position Statement in 2023, which for the first time will be joint, relating to care and related health services

Broader system priorities influencing our BCF approach include

- Continuing to support system recovery from the pandemic
- Strengthening the alignment of resources and shared understanding of collective budgets across Partnership Southwark - including a focus on developing collaborative approaches to mental health services in 23/24
- 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, including pressures arising from demand in numbers and complexity of need (in particular due to possible flu, covid and cost of living pressures), industrial action, cost pressures, workforce recruitment and retention and funding issues.
- Ensuring a good quality and sustainable provider market that can meet demand, particularly in care homes, home care and community health therapy services
- Supporting the ongoing bedding in of the South East London Integrated Care System, including the Integrated Care Board Southwark borough team and the Partnership Southwark arrangements, which were formally established in July 2022.
- Supporting a reduction in health inequalities in line with the refreshed Health and Wellbeing Strategy, and aligned to the Southwark Health and Care Plan (due to be signed off in July 2023)
- Ensuring all services in Southwark contribute to the goal of reducing environmental impact in line with the Partnership Southwark sustainability policy statement as set out on page 33.

Key Changes since previous BCF Plan

Increased national focus on discharge from hospital

There has been a nationally driven increase in the focus of the BCF on tackling delayed transfers of care from hospital. This is reflected by the incorporation of the Additional Discharge Fund into the BCF plan, and a focus on contributing to the delivery plan for recovering urgent and emergency care services, reflecting the ministerial priority to tackle

immediate pressures in delayed discharges. There has been a significant level of system and place level improvement work on discharge as set out in more detail in the section on national condition 3.

At a local level Southwark has responded to this agenda but admission avoidance remains a key focus of the BCF plan that is given equal weight to discharge.

Additional Discharge Fund

The Additional Discharge Fund (previously called the Adult Social Care Discharge Fund) was first incorporated into the BCF in December 2022 as a variation to the core BCF plan. It provided £2.56m non-recurrent funding for a range of Q4 initiatives that directly supported timely and effective discharge, with year-end reporting highlighting a significant impact supporting 817 transfers of care. This has now been made a core part of the BCF allowing for a number of the schemes to roll forward including council led schemes relating to reablement, homecare, double-handed care, extra care and sheltered accommodation, residential and nursing care, recruitment and retention, VCS, step down flats, brokerage and the transfers of care assessment team. The ICB element includes a strong focus on mental health discharge, in particular the provision of supported housing, and on the support required to co-ordinate these discharges. It is also focussed on supporting discharges from acute settings via the provision of increased therapy support where required to enable discharge and the provision of a social worker in ED who can work on pre-admission discharge planning. Additional resources are also allocated to provide a budget for flexible commissioning of services required to assist complex discharges of people on pathways 2 and 3**.** A scheme to support discharges of homeless people has also been funded.

New schemes for 23/24, for which the full year budget increases to £3.9m, include the development plans for intermediate care step down beds provision initiative outlined below and include investments in residential care to increase capacity. It is anticipated that on the basis of national funding growth figures the discharge fund will increase to £7.1m in 2024/25. Plans described for 2024/25 are provisional and will be reviewed later in Q4 23/24.

Development of more specialist bed based intermediate care services

Southwark has one of the highest rates of discharge to normal place of residence in London, reflecting a strong home first approach supported by a range of intensive community based health and care services funded by the BCF. However, an identified capacity gap in our intermediate care offer relates to people who cannot be discharged home as they require specialist bed based rehabilitation services. These patients frequently experience delayed transfers of care, some with a high number of delayed days in hospital after being clinically ready for discharge, due to waiting for a place to be free in a suitable bed based service.

The Council has transferred the running of four older people residential care homes to a new provider who will be a strategic partner to repurpose some of the rooms across the four homes to provide nursing care so that people can ‘age in place’. As part of the redesign of provision, a floor that has been vacant in the lead up to the transfer is being furnished to provide D2A or reablement for up to 17 people from the autumn of 2023. This expansion of provision will support complex pathway 2 step down from acute settings, particularly with multi-disciplinary work within the community to support safe and sustainable transfers of care where people can live safely and successfully in community settings, whether at home (private residential or extra care) or in a regulated setting such as a care home or supported living.

In addition, the ICB are in system wide discussions around options for developing health funded capacity for complex pathway 2 and 3 discharges from additional discharge funding.

Key Budget Changes 2022/23 to 2023/24

Although the BCF predominantly consists of schemes and budgets that have rolled forward from previous years, there are new features to note for 2023/24 relating to the discharge funding, use of 5.66% uplift and some internal funding changes:

Council scheme budget changes:

- The incorporation of the Additional Discharge Fund (council grant element) totalling £2.502m into the BCF as a full year budget

- Net growth in Core BCF budget for council services funded from ICB contribution to BCF of £1.085m (5.66%)* to £20.255m
    - Annual uplifts for a range of council contracts and services (+ £1.152m)
    - New mobilisation funding for intermediate and nursing care contracts (+ £0.1m)

      Less:

    - Efficiency savings relating to voluntary sector hub model (- £0.167m)

- Repurposing of contingency and cost pressure budgets to residential and nursing care (£0.574m)

Note: there is no growth in council IBCF grant funded provision (£17.847m) or DFG (Disabled Facilities Grant) funded provision (£1.686m), although it has been indicated that DFG grant is expected to be increased mid-year.

ICB scheme budget changes:

- The incorporation of the Additional Discharge Fund (ICB devolved amount) totalling £1.599m into the BCF as a full year budget

- Net Growth of £415k (5.66%) in Core BCF budget for ICB services funded from the ICB minimum contribution to £7.841m:
    - Actual growth of £0.450m includes:
    - Annual uplift of NHS Community & Mental Health Contracts (+£0.277m)
    - New investment in GSTT community services (Occupational Therapy, Tissue Viability, Foot Health Therapies) (+£0.173m)

      Other changes (-£0.035m) include:

    - Funding for Speech & Language Therapist for GSTT Community Services (+£0.065m)
    - Consolidation of @home services by including Palliative Care @ Home service (+£0.326m)
    - Transfer of @home nursing budget from additional funding element to core BCF funding (+£0.109m)

      Less:

- Projected contract savings arising from re-procurement and change of provider to Integrated Community Equipment Service (-£0.15m)
- Self-management reductions reflecting 2023/24 contract values (-£0.054m)
- Service Development budget absorbed into ICB running cost budget (-£0.331m)

Changes to 2024/25

The assumed growth for Year 2 is summarised in the table, including a further 5.66% uplift in the ICB minimum contribution, and forecast draft increase in Additional Discharge Fund. These budgets will be subject to review prior to 2024/25 to take into account planning guidance, service evaluation and latest demand pressures.

Note: A full analysis of the BCF budgets is included in the Finance template

Other changes

Falls prevention – new metric and target

A new target has been introduced on admissions to hospital due to falls in over 65 year olds, which aligns with our long standing local priority around falls prevention. Although Southwark's rate on this indicator is close to the London average it is recognised that there is scope for improvement, and a target to reduce the headline rate by 5% has been agreed. A number of BCF services are focussed strongly on falls prevention including the GSTT community falls service, telecare, community equipment (ICES), reablement and rehabilitation, home care, care homes. Falls prevention strategy is part of the Age Well frailty workstream in the Partnership Southwark programme.

Note: Delayed transfers of care – new metric expected to be introduced during 2023/24

It is expected that a new target will be introduced mid-year reflecting patient delays, based on data provided by trusts which will incorporate the delay since "discharge ready date" into mainstream reporting. Plans for this target will be developed as part of mid-year reporting on the BCF.

National Condition 1: Overall BCF plan and approach to integration

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

• Joint priorities for 2023-25

• Approaches to joint/collaborative commissioning

• How BCF funded services are supporting your approach to continued integration of health and social care.

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Joint priorities 2023-25

As set out in the Executive Summary (p.4) the key joint priorities reflected in the BCF relate to avoiding admissions to hospital and care homes and supporting safe and effective transfers of care from hospital, and a number of related areas of focus.

In broader terms as a partnership our priorities are summarised in the Joint Forward Plan which the BCF is an enabler for:

Approaches to joint/collaborative commissioning

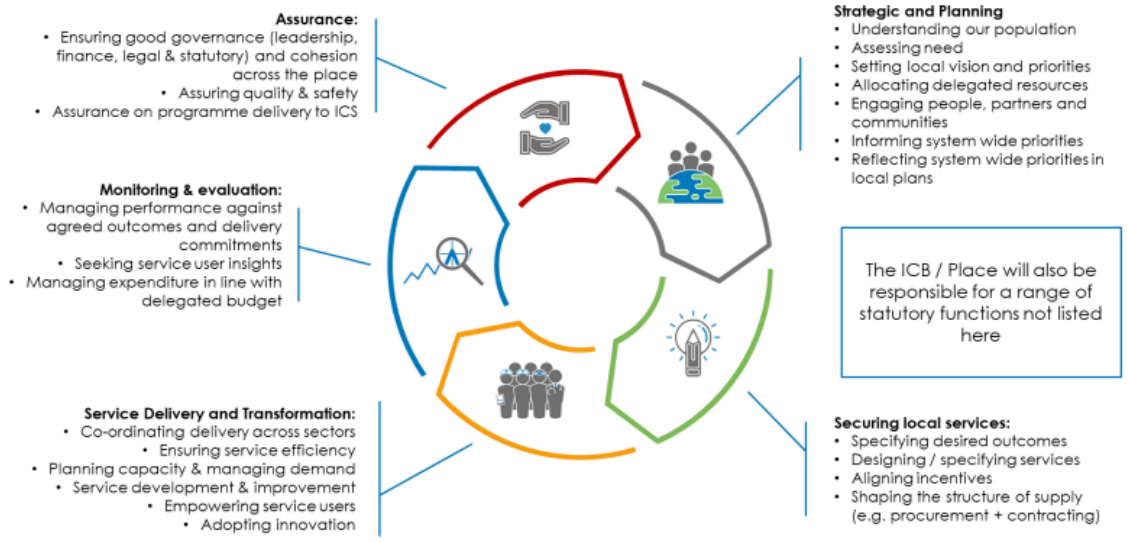
Southwark council and the ICB have a joint commissioning structure with teams responsible for delivering programmes to improve outcomes and address health inequalities for the population: older people and adults with complex needs; children and young people; and healthy populations. The team is jointly funded by the LA and ICB. 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. These arrangements are, of course, subject to the Hewitt Review recommendations.

The joint commissioning teams work 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.

There is a continued commitment to deepening the approach to integrated commissioning. . This includes building on our agreed key principles, our 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).

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



…..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 ('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

How BCF funded services are supporting your approach to continued integration of health and social care.

A number of BCF funded services work closely with partners in a MDT approach, for example:

- The new Transfer of Care Service hospital discharge teams funded via the BCF work in close collaboration with acute and community health teams as part of the discharge process.
- Intermediate Care Southwark is fully funded by the BCF. It is an integrated service model incorporating council staff, council commissioned reablement provider and ICB commissioned intermediate care and community health services under a single management structure
- The Intensive Support Service (previously called Enhanced Intervention Service) is a BCF funded multi-disciplinary team supporting people with learning disabilities and challenging behaviour to remain in lower intensity community based placements. The team includes psychologists from SLAM, a social worker and a therapist from GSTT community team.

Changes to the services being commissioned through the BCF for 2023-25 are set out in the executive summary, and the following sections on National Condition 2 and 3

National Condition 2

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

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

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

The Southwark BCF will 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 as part of personalised care plan. These are part of the wider neighbourhood MDT approach with primary care to preventing admissions for people identified as at risk of admission. Relevant BCF funded schemes include:

- Home care
- Step up reablement and intermediate care
- Urgent Community Response (with increased direct self-referral in 23/24)
- Support to carers
- Telecare and community equipment
- VCS funding – e.g. older people's hub, social prescribing
- Falls service
- Self-management funding for people with long term conditions
- Flexi care/ Extra care
- Mental health and learning disability personal budgets
- Mental health reablement
- Lower limb wound care/ Tissue Viability
- Disabled Facilities Grant

These services will support the wider system in delivering the Fuller report recommendations. The Southwark Fuller Delivery Group has objectives for 2022/23:

- To enable all Primary Care Networks (PCNs) to evolve into integrated neighbourhood teams, supporting better continuity, preventive healthcare and access
- To ensure proactive healthcare and support, targeted at people of all ages living with frailty, multiple long-term conditions and/or complex needs, to help them stay independent and healthy for as long as possible at home, in the place they call home or in their local community
- To improve the management and experiences of people with LTCs.

- To develop strategies to develop high intensity user services and address UEC demand management.
- To ensure patients have access on the day for urgent problems.

This will be in the context of improved access to primary care services in line with primary care recovery plan, which is identified as a key factor in avoidable admissions.

In addition, the objective is supported by our broader prevention strategy such as the focus on hypertension as part of our Vital 5 screening initiative.

Link to discharge strategy: it should be noted that in order to ensure a rounded view on patient flow the system discharge improvement plan set out on page 18 includes a key objective around prevention of admissions, including re-admissions.

National Condition 2 (cont)

Demand and Capacity

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community.

See commentary on demand and capacity planning for national condition 3 on page **21.**

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

BCF funded services play a vital role in enabling people to stay well, safe and independent at home for longer. Examples of how these impacting on the key metrics include.

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions:

- BCF funded community health services including Urgent Community Response enabling referrals for intensive support to prevent admission and the @home service as an alternative to admission, including palliative care at home
- Self-management courses for people with long term conditions, including Self Management UK and Walking Away from Diabetes
- Services such as home care play a key role in supporting the health and wellbeing of people with long term conditions and escalating concerns about health conditions at an early stage, and BCF funded social care services will play a key role in the emerging neighbourhood model with integrated multi-disciplinary working focussing on admissions avoidance objectives.

Emergency hospital admissions following a fall for people over the age of 65

- The BCF provides £857k funding for the Southwark Community Rehab and Falls service. This service specialises in preventing falls, caring for people who have had a fall or fracture or if there are concerns about the risk of falling. The service includes a falls clinic, strength and balance classes and information advice and support to patients and carers.
- Addressing the risk of falls is a key theme running through a range of BCF funded services. Falls risk assessments underpin the provision of reablement and rehab, community equipment, minor adaptations and major adaptations through the Disabled Facilities Grant.
- The telecare services provides specific services enabling falls to be responded to, including specialist staff and equipment for lifting people after a fall rather than calling an ambulance.

The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

- The BCF provides funding for an extensive range of personalised home based services that enable people to live independently and safely at home in the community for as long as possible, avoiding or delaying the need for permanent admissions to care homes. This is a key objective of our home care, extra care,

reablement, intermediate care, rehab, housing adaptations, equipment, voluntary sector hub and carers support services.

- Discharge related services are focused on a home first approach rather than transfer to a care home as set out in this plan
- A number of these areas have been strengthened through the use of the additional discharge fund, including schemes to fund step down flats and strengthen supported housing options in mental health

National Condition 3

Use this section to describe how your area will meet **BCF objective 2: Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

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

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Additional Discharge Fund: The Additional Discharge Fund has provided significant investment for this objective as set on page 6.

South East London Integrated Care System – in depth review of discharge and 2023-2025 improvement plan for transfers of care

The key development in terms of planning for improving transfers of care relates to the development of this ICS plan which Southwark intends to actively deliver with partners.

Building on the outputs of a number of system and place level discharge related workstreams, in March 2023 the ICS held a Discharge Summit to enable system leaders to come together and discuss how to improve both timeliness and quality of discharge from our acute and mental health providers. A wealth of suggestions came from that discussion and, as a system, it was agreed to develop a SEL Discharge Plan that all partners in the ICS can commit to delivering. This System Plan has been developed in conjunction with the Discharge Solutions Improvement Group (DSIG) and the SEL MH Discharge Group (sub-group of DSIG) and aims to define our mission, objectives and the measures by which we will deliver improvement over the next two years (2023-2025), aligning to BCF improvement plans.

A mission statement for the plan was agreed as follows:

"When medically and therapeutically ready, our residents will receive good, safe and timely transfer of care from hospital to home. Irrespective of whether they have mental or physical health needs, they will feel that the care on offer is to help them recover as quickly as possible with no hospital stay longer than needed".

High level objectives were agreed and detailed action plans for each objective is set out in full overleaf.

Discharge Improvement Plan Objective 1: We will work to a **common framework** to deliver transfer of care standards

South East London Integrated Care System

Standards: a) Complimentary model for TOC Hubs with agreed language and definitions; b) Home first wherever possible (within a D2A process); c) Standardised discharge policies where appropriate across acute providers (physical and mental health)

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Implement 10 immediate actions and 7 recommendations from SEL TOC review with initial focus on priorities 1-3: **1) SEL discharge plan owned by all system partners with shared ambition** **2) SEL operating model for TOC/Flow hubs (including agreed common language and definitions)** **3) Significantly increased focus on P0 with dedicated P0 co-ordinators in hubs** 4) Regular discharge audit programme across SEL 5) Review of data captured to align and expand current data and review targets to improve performance 6) Strategic review of most efficient TOC/Flow hub model for SEL 7) Hub access to Social Care management IT systems	TOC Review Delivery Tracker Oversight and collection and monitoring of P0 data including complexity and delay reasons Non CTR by Pathway, number of patients discharged, TOC LoS by pathway and borough	SEL TOC Review	1) DSIG 2) Sub-group: TOC leads (SEL co-ordinated) 3) Acute DOOs	Q1 23/24 Q3 23/24 Q3 23/24	DSIG DSIG AFIG
B)	Commission demand and capacity planning and associated reviews for key areas (e.g. intermediate care, weekend working/extended hours and mental health)	Base-line audit HICM maturity assessment	TOC – HICM – Change 5	SEL commissioned	Q2 23/24	DSIG & BCF
C)	Embed the Mental Health Discharge Framework and improve delivery against baseline assessment	Base-line audit	100 day MH challenge	SEL MH Discharge Group	Q4 23/24	DSIG

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Discharge Improvement Plan Objective 2: We will secure pathways that are **safe, personalised and promote independence and recovery**

South East London Integrated Care System

Standards: Clear processes for transferring patient care to give all patients opportunity to recover in the community: a) before an assessment for their reablement and long-term care needs takes place (physical health); b) through shared lives and stepdown accommodation options with psychosocial support (mental health). Where recovery is not an option c) to maximise quality of life in final months, weeks or days of a person's life.

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Improve, promote and enable through the transfer of care model: • Greater access to intermediate care and reablement services for our patients • Providing these services at the right time to maximise the patient's recovery. Achieving successful outcome for the patient around wellbeing and living as independently as they can with no ongoing or minimum levels of on-going support. Place-based funding and investment plans aligned to this action to evidence where local investment will support delivery	Reablement ADASS monthly return (SALT) AND BCF 91-day Intermediate Care Metrics SEL Discharge Dashboard		Place-based	23/24	DSIG
B)	Implement evidence based best practice, including discharge to assess and home first models as our embedded approach to transfer of care e.g. SEL Policy and action cards on how to transfer care for out of borough patients without delay	ASC outcome framework BCF indicator dashboard	Discharge guidance TOC – HICM Bromley policy & action cards	Place-based improvement spread across SEL	23/24	DSIG & PELS
C)	Develop the range of supported housing and shared lives initiatives for fragile mental health patients stepping down into the community with psychosocial support enabling residents to regain their skills to cope with activity around daily living (independence).	Place based BCF metrics	Review PSSRU Outcome measure	Place based and MH Discharge Group/BCF	23/24	DSIG and PELS
D)	Early planning for patients requiring end of life services that supports the aims of dying well. Training of all staff working in discharge to proactively identify patients who are approaching the end-of-life care phase to support earlier access to palliative care services. Making advanced care planning and use of universal care plan the norm.	Audit of use of universal care plan Reduction in number of people dying in hospital EoL national data set	SEL Joint Forward View for PEOLC care (pg. 200)	AFIG, place based and EoL steering group		DSIG, AFIG & EOL steering group

Discharge Improvement Plan Objective 3: We will **meet complex patient needs**

Standards: SEL has clear processes for transferring patient care into the community to: a) continue treatment/ recovery that enables longer term planning; b) meets planned and unplanned health needs and c) enables where possible a patient to die in the most suitable setting (of their choice)

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Developing safe and appropriate pathway for patients with complex clinical or discharge challenges: • dementia & delirium pathways • transfer of care to bed-based services for patients with complex needs Recognising that these will be developed at SEL level where possible for local adoption based on population need	Readmission rates	Good practice evidence base to be gathered	D&D sub-group Place-based leads linking with CH group	Q3 Q3	DSIG
B)	Develop a SEL approach to patient deterioration escalation and pre-crisis planning (mental and physical health)	Readmission rates		Identified clinical leads (tbc)	Q3	DSIG
C)	For patients with complex needs reaching end of life engaging the range of services (e.g. health and care support, hospice care, accommodation and equipment) to enable a dignified and comfortable death wherever possible	Audit of delivery of care against universal care plan	SEL Joint Forward View for PEOLC care (pg. 200)	AFIG, place based and EoL steering group		DSIG, AFIG & EoL Steering Group
D)	Maximising the opportunities to adopt pooled funding and risk/gain share approaches to reduce TOC delays	TOC delays		Sub group	Q2	DSIG
E)	Place-based funding and investment plans aligned to the SEL discharge plan to evidence where local investment will support delivery of SEL objectives	Local discharge improvement plans and delivery updates		Place-based	Q2	DSIG

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Discharge Improvement Plan Objective 4: We will focus on **avoiding unnecessary admissions**

Standard: To ensure people are only admitted to hospital when their care can no longer be managed at home. People requiring access to urgent and emergency care are not admitted unless their clinical condition requires it

Actions		Measures	Evidence Base	Who *(Place, SEL level, Sub-group)*	When	Governance
A)	Consistent community offer to support people staying independent at home for as long as possible. Involving voluntary sector services, strength-based support systems (including social prescribers) and active interventions such as intermediate care and reablement as a step-up service.	ASCOF - The proportion of older people (aged 65 and over) at home 91 days after discharge from hospital into reablement / rehabilitation services				Community Provider Network
B)	Admission avoidance/ACPs for ambulance service and hospital front door, with a front door discharge to assess approach. Adhering to any end-of-life plans in the universal care plan where the patient has chosen to die at home or other non-hospital setting.					Local UEC Board
C)	Understanding patient behaviours and how this drives their decision making in times of urgent need					Local UEC Board
D)	Review our key existing pathway to avoid admissions e.g. urgent community response (UCR) offer, reablement, MH crisis offer, virtual wards to ensure we are optimising available capacity. Clear access criteria and can be referred from ED.					Local UEC Board

Patient experience of discharge project

An innovative multi-agency project has been established to gain in-depth intelligence about patient experience of discharge. This will help partners understand how best to improve discharge, with a focus on effective communication and consultation with patients. Community researchers recruited by the voluntary sector have been trained in ethnographic interviewing techniques by a specialist research company. They will accompany a sample of patients during their discharge from hospital and ask them about how they are experiencing the process, what they have been told and understand about what is happening and interview two weeks later to understand what actually happens. The report is expected to be available in July.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as

- where number of referrals did and did not meet expectations
- unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
- patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);

- approach to estimating demand, assumptions made and gaps in provision identified - planned changes to your BCF plan as a result of this work.

- where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
- how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Estimates for demand and capacity in intermediate care services are based on latest service data projected forward.

The learning from 2022/23 is that we are currently not able to populate the data fields in the national Capacity and Demand template in a consistent and accurate manner. For example, discharge information at a borough level by pathway and service received is not generated by acute data systems. In addition, the local community health provider has had major IT/IS system failures during the year and has been unable to report. This remains an area for development during 2023/24 that is expected to be resolved in the autumn of 2023.

The main source of information used for assessing gaps between demand and capacity for intermediate care is real time operational data of the internal flow hubs, which provides details on all currently delayed patients including the identified reason for the delay. This tells us for the acute delays the key delay reasons relating to care packages (as opposed to delays relating to ongoing NHS care) are as follows:

- availability of suitable care home placement able to meet high levels of acuity in patients
- availability of bed based rehabilitation for those with highest needs who cannot be supported at home
- capacity of community health services to take discharge referrals for therapy at home

Discharges from mental health inpatient settings are most frequently caused by lack of capacity in supported housing providers who are able to support high needs individuals upon discharge. Homelessness and NRPF is also a common factor.

It is a known risk that the lack of capacity in specific areas may result in discharges into services that are not the ideal match for assessed needs, as well as delays in the discharge itself.

These identified gaps are in the process of being addressed through the BCF funding, in particular the Additional Discharge Fund and associated commissioning strategies including:

- Commissioning of new nursing home in borough and initiatives to maximise capacity across the nursing home and residential home bed base
- Development by council of more specialist bed based reablement care services as set out on page 6
- Extra care / flexi care / step down flats
- ICB commissioning plans for rehab beds for pathway 2 and 3 discharges for both acute and mental health under development
- Funding of Kings Outreach Therapy service to provide additional therapy support to discharge when the local community health provider is unable to accept a referral
- Recruitment and retention initiatives (Care Home Charter)
- Homelessness discharge scheme

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

Southwark has the highest rate of discharges to usual place of residence in London. To support our strong home first ethos, the following BCF funded services will actively support discharge to normal place of residence, providing options for care packages that make returning home a safe and effective transfer.

- Internal flow hubs pursuing home first discharge to assess approach
- Reablement services including double handed care
- Community Health @home service and rehabilitation/ intermediate care
- Home care, including overnight intensive home care (Night Owls)
- Residential care and nursing care and flexi care/ extra care
- Step down flats
- 7 day hospital discharge team
- ICES and Telecare
- VCS services such as Hospital Buddies
- DFG including handy person service
- Palliative care at home service

National Condition 3 (cont)

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

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. Aspects of the model are included in the SEL ICS improvement plan, and the model is used in Southwark as a tool to benchmark for good practice and to help identify service improvement priorities. A recent update against the criteria confirmed that current arrangements still fall into the mature or established banding for each change area. 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
- Internals flow hubs to ensure full compliance with the setting of expected dates of discharge and an MDT plan, ensuring effective discussion and communication of this, including with family/friends, with preparation during hospital stay to effectively provide a safe discharge
- 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
- Develop data systems to enable effective use of intermediate care capacity and demand model
- Maintain contracting with 10 core providers of home care for the borough to ensure capacity to respond to pathway 1 packages of care in a timely manner.

Change 3: Multi-disciplinary (MDT) working

- Primary care involvement in the MDT for discharge planning where required

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
- Ensure continuation of strong home first approach despite pressures on system, commissioning additional capacity as required from discharge funding
- Review Intermediate Care Southwark pathway to ensure appropriate patients are referred and receive care within best practice timeframes

Change 5: Flexible working patterns

- Build an integrated 7 day service model, increasing the number of patients leaving with packages of care at weekends
- Ensure the internal flow hubs at both acute hospital sites working seven days a week, with access to clinical and social care colleagues to support decision making regarding discharge arrangements.

- 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 (TA) model is fully embedded with continued use of TA documentation as standard practice by discharge hubs in format agreed with care homes

Change 7: Engagement and choice

- Ensure choice protocol (Safe to Transfer Discharge Policy) that was signed off across SEL in April 2023 is fully embedded and operating effectively

Change 8: Improved discharge to care homes

- Respond to recommendations from Care Home listening event in early 2023
- Development of Transfer of Care (TOC) Passport which provides essential information about a patient for care homes, so they are confident in receiving the admission with all necessary information on arrival.
- Enable more weekend discharges to care homes
- Maximise commissioning options to increase care home capacity to accommodate complex needs, including options from use of discharge fund

Change 9: Housing and related services

- Ensure expected dates of discharge incorporate housing related needs
- Continuation of homeless health project to facilitate discharges
- Extend model of housing advice workers with discharge teams to mental health

These changes will be picked up under workstreams including the Lambeth and Southwark Discharge Operational Delivery Group, the ICS Discharge Solutions Group and mental health discharge group, and specific discharge related workstreams. The changes will be absorbed into the SEL ICS discharge improvement plan monitoring

National Condition 3 (cont)

Care Act and Supporting Unpaid Carers

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

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

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.

Supporting unpaid carers.

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.

There is a dedicated service for young carers, which provides emotional and practical support to young carers with caring responsibilities. This service 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 commissioned services help 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

In 2022 The Institute of Public Care completed carer training for staff across ASC, Ageing Well Southwark and Commissioning. The workshops were co-produced with carers and representatives from the voluntary sector. The newly designed carer pathway will embed the ethos, principles and approach in order to further:-

- 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

Disabled Facilities Grant (DFG) and wider services

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

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 been awarded a budget of £1.686m for 23/24, which is the same allocation funding for 22/23. 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. For 23/24 we will continue to focus on clearing our backlog of cases, which currently stands at 51 cases on the waiting list, and ensuring emergency cases are dealt with immediately. The team continues to reduce the number of people on the waiting list by reducing the time clients are waiting, which currently stands at 6 months, we intend to reduce this to four months, by working through cases more efficiently. We received a total of 93 referrals from OT, on average 8 per month, during April 22 to March 23.

From April 22 to April 23, we have completed 123 major adaptations, which compromised of:

- 82 Level access showers
- 22-bathroom alterations
- 12 step/ stairlift installations
- 3 Closomat installations
- 3 building alterations
- 1 Door entry system

We have set a target of 150 major completions in 2023/24.

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 and complex cases, staffing etc

Other specific areas of improvement:

- The DFG service has now gone to advertising to recruit a Senior Occupational Therapist. The role will work across new homes, the HIA service and voids. 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 service has updated reporting on Case manager, the IT system used to record adaptation works, this is to monitor progress of cases and ensure progress is made in a timely manner.
- The service implemented satisfaction surveys for completed works. From April 22 to March 23, 46 satisfaction surveys were completed for HIA, respondents said they were happy with the service. Some of the comments were

'I would recommend the service', 'the HIA provided an excellent service'.

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

CASE A

Client is female in her 60's and a Housing Association tenant living by herself. Client receiving palliative care at home. Client was referred to the Home Improvement Agency following an Occupational Therapists assessment, the outcome of the assessment recommended the provision for level access shower facilities with wall mounted drop down seat and grab rails.

The adaptations installed had a positive effect allowing the client to maintain her independence, dignity and privacy. Client was very happy with her new bathroom and was satisfied with the overall service. Client stated that the contractor's work was excellent, they were polite and very helpful. Client had a positive experience therefore felt able to recommend the service to others.

CASE B

Client has a range of health issues including multiple sclerosis, collagenous colitis, kidney failure, lupus, breast and lung cancer. The client was assessed by Occupational therapy to replace the bath with a shower, these works were carried out. The client responded to say that the works enabled her to maintain her independence and she was able to shower.

Handy person service.

The handyperson service has been assisting residents, regardless of tenure, (aged 60 or over, or with a disability of any age) with a range of works. The number of works completed between April 22 to March 23, was 1457, which is broken down as follows:

- 444 minor repairs
- 746 Key safes
- 238 Lightbulb changing
- 29 other (decorating, smoke alarms)

Minor repairs include putting up shelves, assembling furniture, moving furniture, which has enabled a new bed or other furniture to be delivered to the persons property.

75% of the key safes installed, approximately – 560 homes, were to enable someone to be discharged from hospital, with approximately just under 200 cases to enable them to receive care in the community. In all cases to enable the resident to remain living in their home.

For 2023/24 our aim is to increase the number of works we carry out across the borough, by promoting the handyperson service to more people including residents living in their own home. We are working with the communication team to put out several adverts across a range of mediums including online newsletters, inserts in council tax and rent statements etc.

From April to March 23, the handyperson service carried out a total of 123 satisfaction surveys. Total satisfaction for the year was at 100%. The consensus from all *'clients was that they trusted the service, happy to get works done, they felt that the service was wonderful and reliable, it enabled them to feel safe, secure at home and enabled them to maintain their independence'.*

Additional information (not assured):

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

No (focus has been on recovering core DFG waiting list)

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan

- How equality impacts of the local BCF plan have been considered

- How these inequalities are being addressed through the BCF plan and BCF funded services

- Changes to local priorities related to health inequality and equality and how activities in the document will address these

- Any actions moving forward that can contribute to reducing these differences in outcomes

- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

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 are set out below. These are underpinned by a commitment to ensure tackling inequalities is embedded across all our policy making, service design and delivery.

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

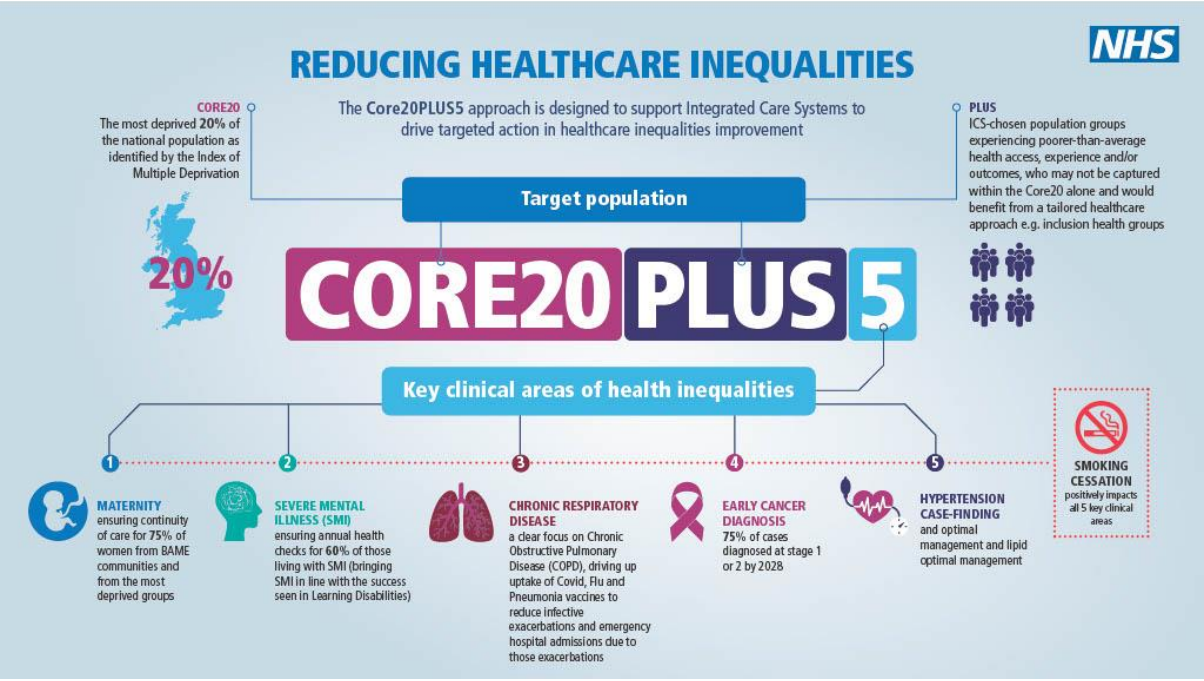
Drive 2: Healthy employment and good health for working age adults across the health and wellbeing economy: the BCF provides funding for costs associated with the Southwark ethical care charter, which helps ensure good employment practices in commissioned services.

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 draft **Health and Care Plan** and an associated outcomes framework will be developed during 2023/24 and provide detail on the delivery of this drive area. The BCF will be fully aligned with this plan.

Core20PLUS5: It is a priority to develop the capacity to support a Core20PLUS5 approach in 2023/24, working with NHS analytics teams and public health to identify key population groups to target improvements in heath inequalities. This will complement the current Vital 5 programme which focuses on people with key risk factors for poor health outcomes. The Core20PLUS5 approach is illustrated in the diagram below:



The draft Health and Care Plan sets out a commitment to embedding an approach to tackling health inequalities across all our policy-making, services and delivery, including BCF development. It builds on the Partnership Southwark Recovery Plan which 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.

The BCF funding is a key enabler of the adult's focused workstreams: 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.

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. The Additional Discharge fund has provided resources to extend these principles to the care home workforce through the Residential Care Charter.

Environmental impact of the BCF

Partnership Southwark is committed to developing its approach to sustainability to minimise the adverse impact services have on the environment, particularly in relation to climate change and air quality. This is reflected in the Partnership Southwark Environmental Sustainability Policy Statement in January 2023 which gives a commitment to developing a mutually supportive approach to delivering organisational sustainability plans and ensuring all partnership decisions consider sustainability implications.

According to the Sustainable Development Unit, the NHS is the biggest public sector contributor to climate change in the whole of Europe. Hospitals have a major role to play in this as they have such a high carbon footprint. The BCF has an indirect role in this as it supports the overall strategy of developing a neighbourhood model with health and care closer to home, reducing admissions and minimising length of stay in hospital - which in the long term will shift the balance of resources away from hospital activity. In addition, it is recognised that all community based service providers funded by the BCF have a role to play and will be supported to minimise their environmental impact. For example, the community equipment service has a strong focus on increasing recycling and re-use of equipment.

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

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

5. Income

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

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

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

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

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

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

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

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

6. Expenditure

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

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

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

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

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

6. Area of Spend:

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

7. Commissioner:

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

8. Provider:

- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

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

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

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

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

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

7. Metrics

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

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

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

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

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

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

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

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

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

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

			Complete:
Health and Wellbeing Board:	Southwark		Yes
Completed by:	Adrian Ward		Yes
E-mail:	adrian.ward@selondonics.nhs.uk		Yes
Contact number:	0208 176 5349		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	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	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Andrew	Bland	andrew.bland@selondonics.nhs.uk	Yes
	Additional ICB(s) contacts if relevant		Martin	Wilkinson	martin.wilkinson@selondonics.nhs.uk	Yes
	Local Authority Chief Executive		Althea	Loderick	althea.loderick@southwark.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		David	Quirke-Thornton	david.quirke-thornton@southwark.gov.	Yes
	Better Care Fund Lead Official		Adrian	Ward	adrian.ward@selondonics.nhs.uk	Yes
	LA Section 151 Officer		Clive	Palfreyman	clive.palfreyman@southwark.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Southwark

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,686,144	£1,686,144	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£28,095,959	£29,686,191	£28,095,959	£29,686,191	£0
iBCF	£17,847,349	£17,847,349	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£1,287,225	£1,287,225	£0
Additional ICB Contribution	£1,200,520	£1,200,520	£1,200,520	£1,200,520	£0
Local Authority Discharge Funding	£2,502,171	£4,153,604	£2,502,171	£4,153,604	£0
ICB Discharge Funding	£1,599,000	£2,971,000	£1,599,000	£2,971,000	£0
Total	**£54,218,368**	**£58,832,033**	**£54,218,368**	**£58,832,033**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£7,984,075	£8,435,974
Planned spend	£8,264,564	£8,708,382

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£19,508,213	£20,612,377
Planned spend	£20,254,645	£21,401,059

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	222.0	187.0	225.0	195.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,940.0	1,843.0
	Count	473	450
	Population	25997	25997

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	96.8%	96.8%	96.8%	96.8%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	562	540

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

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 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Southwark

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

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

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

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

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

3.2 Demand - Community

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

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

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

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Analysis gives best estimates, caveated due to data issues including limitations in reporting on requested data items. Rehab, UCR and at home estimates only based on last available 12 months data before system outage. Capcity and demand data to be built on during the year as community health provider implements new data system. Discharge data reflects estimated apportionment of ICB Operating Plan trajectories to borough level. Estimated 5% pathway zero receive some form of social or VCS support. Demand for intermediate care from the community for vol sector services is zero as VCS do not provide formal Intermediate Care. Short term domiciliary care / other social care incorporated into reablement. Unmet need data not available hence capacity reflects demand in baseline data and projections. Mental health not included as comparable data not available.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

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

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	42	44	44	42	43	40	44	42	39	42	39	41
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		34	36	35	34	35	32	36	34	31	33	31	33
OTHER		7	7	7	7	7	6	7	7	6	7	6	7
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Reablement at home (pathway 1)	18	21	17	11	14	32	23	36	27	26	26	39
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		14	17	14	9	11	25	19	29	22	21	21	31
OTHER		3	3	3	2	2	5	4	6	4	4	4	6
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	61	61	61	61	61	61	61	61	61	61	61	61
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		49	49	49	49	49	49	49	49	49	49	49	49
OTHER		9	9	9	9	9	9	9	9	9	9	9	9
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	1	1	1	1	1	1	1	1	1	1	1	1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	9	9	9	9	9	8	9	9	8	9	8	9
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		7	7	7	7	7	7	7	7	7	7	7	7
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	10	11	11	6	8	7	10	10	7	11	9	9
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		8	9	9	5	6	5	8	8	6	9	7	7
OTHER		2	2	2	1	1	1	2	2	1	2	1	1
Totals	**Total:**	276	288	280	255	265	290	291	312	280	293	281	312

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	120	120	120	120	120	120	120	120	120	120	120	120
Reablement at home	39	56	56	35	21	17	23	29	22	22	22	12
Rehabilitation at home	54	54	54	54	54	54	54	54	54	54	54	54
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	83	87	86	82	85	79	87	82	76	82	76	81	0%	100%	0%
Reablement at Home	Monthly capacity. Number of new clients.	35	42	34	22	27	62	46	70	53	50	50	76	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	119	119	119	119	119	119	119	119	119	119	119	119	100%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2	100%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	17	17	17	17	17	17	17	17	17	17	17	17	100%	0%	0%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	20	22	22	12	15	13	20	20	14	22	17	17	100%	0%	0%

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	120	120	120	120	120	120	120	120	120	120	120	120	100%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	39	56	56	35	21	17	23	29	22	22	22	12	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	54	54	54	54	54	54	54	54	54	54	54	54	100%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Southwark

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Southwark	£1,686,144	£1,686,144	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£1,686,144**	**£1,686,144**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Southwark	£2,502,171	£4,153,604	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS South East London ICB	£1,599,000	£2,971,000	Yes
Total ICB Discharge Fund Contribution	£1,599,000	£2,971,000	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Southwark	£17,847,349	£17,847,349	Yes
Total iBCF Contribution	**£17,847,349**	**£17,847,349**	

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

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
Southwark	£1,287,225	£1,287,225	Council's core budget	Yes
Total Additional Local Authority Contribution	**£1,287,225**	**£1,287,225**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS South East London ICB	£28,095,959	£29,686,191
Total NHS Minimum Contribution	**£28,095,959**	**£29,686,191**

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

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
NHS South East London ICB	£1,200,520	£1,200,520	Additional ICES budget	Yes
Total Additional NHS Contribution	**£1,200,520**	**£1,200,520**		
Total NHS Contribution	**£29,296,479**	**£30,886,711**		

	2023-24	2024-25
Total BCF Pooled Budget	**£54,218,368**	**£58,832,033**

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

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Southwark

<< Link to summary sheet

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£1,686,144	£1,686,144	£0	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£28,095,959	£28,095,959	£0	£29,686,191	£29,686,191	£0
iBCF	£17,847,349	£17,847,349	£0	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£0	£1,287,225	£1,287,225	£0
Additional NHS Contribution	£1,200,520	£1,200,520	£0	£1,200,520	£1,200,520	£0
Local Authority Discharge Funding	£2,502,171	£2,502,171	£0	£4,153,604	£4,153,604	£0
ICB Discharge Funding	£1,599,000	£1,599,000		£2,971,000	£2,971,000	£0
Total	**£54,218,368**	**£54,218,368**	**£0**	**£58,832,033**	**£58,832,033**	**£0**

Required Spend

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

	2023-24			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,984,075	£8,264,564	£0	£8,435,974	£8,708,382	£0
Adult Social Care services spend from the minimum ICB allocations	£19,508,213	£20,254,645	£0	£20,612,377	£21,401,059	£0

Checklist

Column complete:

Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

										Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Enhanced Intervention Services - ICB	MDT providing enhanced psycholgical support for people with learning disabilities and challenging behaviour	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£228,404	£241,331	100%
2	Admissions avoidance - ERR and @home	Community health services enhanced rapid response and @home service	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		2100	2100	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£5,044,499	£5,330,018	49%
3	GP Support @ Home Acuity	Service provides acute clinical care @ home. Multidisciplary team providing quality care at the persons ow home	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£264,654	£279,633	3%
4	@Home Geriatric Assessment	Service providing geriatric assessment and advance care planning in a persons own home	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£31,320	£33,093	0%
5	@Home Integrated Care Fellows	At home integrated Clinical Care Fellows expertise	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£86,130	£91,005	1%
6	Falls service	Southwark community rehab and falls service: specialising in preventing falls, supporting people who have previously had	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£856,949	£905,452	54%
7	Occupational Therapy-Southwark	OT working with falls service supporting people who after an injury or illness have functional, cognitive and phsychological	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£48,936	£51,706	39%
8	Tissue Viability - Community	Service providing treatment, advice and education on treatment of wounds and pressure ulcers in community	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£58,415	£61,722	39%
9	Therapies - Foot Health Community	Assess, treat and advise people with foot conditions. Podiatrists who support foot and lower limb care.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£65,489	£69,195	39%
10	Palliative Care @ Home	Service provides palliative nursing care at home, also support for families of people who are seriously ill.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£326,236	£350,360	29%
11	Self-management	Self-management for people with long term conditions	Prevention / Early Intervention	Other	Self-management courses/resource				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£163,031	£172,259	100%
12	EIS - Speech & Language Therapist	GSTT therapist working in EIS team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£65,133	£68,820	100%
13	Neuro-rehab team - GSTT	Support workers for GSTT community neuro-rehab team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£205,691	£217,333	100%
14	Community Equipment Service	ICES Contract - CCG costs - BCF additional contribution	Assistive Technologies and Equipment	Community based equipment		2862	3120	Number of beneficiaries	Community Health		NHS			Private Sector	Additional NHS Contribution	Existing	£1,200,520	£1,200,520	100%
15	Community Equipment Service	ICES Contract - CCG costs - BCF core contribution	Assistive Technologies and Equipment	Community based equipment		807	880	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£296,427	£313,205	100%
16	Behavioural Support - LD and autism	Community team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
17	Dementia - Enhanced Neighbourhood	Integrated Care Planning and Navigation	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£184,177	£184,177	53%
18	Homecare Quality Improvement	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		107309	113699	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,114,000	£2,330,840	11%

19	Residential & Nursing	Residential and Nursing Placements	Residential Placements	Care home		55	55	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,691,939	£2,943,455	12%
20	Protect Adult Social Care - Residential Care	Residential Care	Residential Placements	Care home		48	48	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,254,877	£2,479,452	22%
21	Mobilisation - Intermediate and Nursing Care	Nursing and reablement placements	Residential Placements	Care home		2	2	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	New	£100,000	£100,000	1%
22	Discharge to Assess - Council Costs	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£540,600	£573,036	100%
23	Reablement - OT Team ICS	Intermediate Care Services	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£467,250	£490,613	100%
24	Hospital discharge Team	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,879,976	£1,973,974	90%
25	Housing Worker Discharge Team	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
26	Intermediate Care	Intermediate Care Services	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		300	300	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,205,817	£1,278,166	84%
27	Night Owls - overnight intensive	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		13000	13000	Hours of care	Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution	Existing	£241,000	£241,000	99%
28	Reablement Team	Intermediate Care Services	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		525	525	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,033,575	£2,135,254	100%
29	Community Mental Health Services	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£694,300	£735,958	61%
30	Enhanced Psychological Support for those	LD clients	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£29,000	£29,000	5%
31	Learning Disability - Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£223,660	£237,080	6%
32	Mental Health Reablement	Community Based Schemes	Reablement in a persons own home						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£160,730	£170,374	8%
33	Mental Health - Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£636,000	£674,160	42%
34	Mental Health Broker	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£63,000	£66,150	100%
35	Mental Health Complex Cases Worker	Community Based Schemes	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
36	Mental Health Discharge Worker	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
37	Psychiatric Liaison (AMHPs and reablement)	Community Based Schemes, admissions avoidance	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£315,000	£330,750	36%
38	Care Act Funding	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Carers				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,000,000	£1,000,000	100%
39	Service Development and Change	Funding for integration projects	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£45,000	£45,000	4%
40	Carers Strategy	Carers Services	Carers Services	Respite services		125	125	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£450,000	£450,000	87%
41	Unpaid Carers	Support for carers of people with dementia	Carers Services	Respite services		30	30	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
42	Community Equipment	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		250	280	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£562,000	£562,000	22%
43	Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		98	105	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£623,995	£623,995	59%
44	Voluntary Sector Prevention Services	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		Joint	28.0%	72.0%	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,081,251	£1,081,251	87%
45	Voluntory Sector Carers work	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£400,000	£400,000	100%
46	iBCF funding plans - home care	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		523990	521608	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£10,327,850	£10,327,850	42%
47	iBCF funding plans - nursing care homes	Residential Placements	Residential Placements	Nursing home		79	79	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£4,174,334	£4,174,334	17%
48	iBCF funding plans - Transformation fund to improve	Community Based Schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	iBCF	Existing	£250,000	£250,000	100%
49	IBCF Reablement and Intermediate bed based care	Intermediate Care Services	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement accepting step up and step down users		151	151	Number of Placements	Social Care		LA			Private Sector	iBCF	Existing	£999,749	£999,749	100%

50	Residential care for older people	Residential Placements	Residential Placements	Care home		8	8	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£400,000	£400,000	2%
51	Nursing Care for older People	Residential Placements	Residential Placements	Nursing home		6	6	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£300,000	£300,000	3%
52	Home care for older people	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		44420	44083	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£870,648	£870,648	4%
53	Flexicare - Housing Based Scheme	Extracare - Flexi-care	Residential Placements	Extra care		22	22	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£524,768	£524,768	24%
54	Disabled Facilities Grants	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		150	150	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,686,144	£1,686,144	100%
55	Community Equipment	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		250	280	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£246,850	£246,850	10%
56	Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		98	105	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£444,626	£444,626	42%
57	Voluntary Sector Prevention Services	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£482,749	£482,749	39%
58	Voluntory Sector Carers work	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£113,000	£113,000	28%
59	Further investment into Nursing Care	Further investment into the Nursing Care sector (24/25 subject to review) to allow for a new care home within the borough to	Residential Placements	Nursing home		22	22	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£713,000	£1,183,580	3%
60	Improvements in Reablement Outcomes	Further investment into reablement packages to improve outcomes (24/25 subject to review). This would increase the	Home-based intermediate care services	Reablement at home (to support discharge)		44	44	Packages	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£200,000	£332,000	10%
61	Enhanced resources into Homecare	Enhanced investment into double handed care placements (24/25 subject to review) to allow for more effective discharge to an "at	Home Care or Domiciliary Care	Domiciliary care packages		9238	9328	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£220,673	£366,317	1%
62	Maximising the use of Extra Care and sheltered	Investment in Extra Care Housing, Sheltered and Alms housing (24/25 subject to review) to facilitate higher acuity discharges from	Housing Related Schemes						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£77,000	£127,820	4%
63	Residential Care Charter	Accelerated investment in to the LA's in-borough provider's (24/25 subject to review) in providing a supplement which would	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£150,000	£249,000	50%
64	Hospital Buddies	Supports to those who are due to be admitted to hospital for elective surgery, with discharge preparation (24/25 subject to	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£20,000	£33,200	100%
65	Double Handed Care	Occupational Therapist based in the ToC Review team (24/25 subject to review) to look at all new residents being discharged	Other						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£55,000	£91,300	100%
66	Transfer of Care Assessment Team	Community based team to complete assessments in the community as a part of the D2A model to facilitate quick and safe	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£175,000	£290,500	10%
67	Cost of Living Crisis Worker	Non-qualified staff member to support people who are due to be discharged from Hospital or recently discharged with the	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£35,000	£58,100	100%
68	Step Down Flats	To fund 7 step down flats in extra care sheltered housing. (24/25 subject to review).This will enable pathway 1	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)		35	35	Number of Placements	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£188,998	£313,737	25%
69	Increased Brokerage Support	This additional funding helped to provide the right care and the right time for the right people and speed up pathway 1 and 3	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£27,500	£45,650	4%
70	Retention initiative for OT Workers	Investment into earmarked initiative for Occupational Therapists retention payment to assist in retaining staff please. (24/25	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£40,000	£66,400	0%
71	Further Investment into Residential Care	Further investment into the Residential Care sector (24/25 subject to review) to allow for a new provider within the borough to	Residential Placements	Care home		11	11	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	New	£600,000	£996,000	2%
72	Mental Health Discharge Housing Workers	MH Discharge workers to support MFFD homeless on the ward and those currently in B&B. (24/25 subject to review). Facilitate	Housing Related Schemes						Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£40,000	£74,321	100%
73	Expand step down housing	Step down flats (24/25 subject to review) - Create capacity in complex care placement for MFFD patients currently on the ward	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement (to support discharge)		48	0	Number of Placements	Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£144,500	£268,486	100%
74	Expand step down housing options	Placement review workers (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£36,000	£66,889	100%
75	Additional Home Treatment Team (HTT) capacity	HTT advanced practitioners to support individuals discharged to step down accommodation (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£40,000	£74,321	100%
76	Shared lives support	Step down service for people discharged from hospital. (24/25 subject to review). Increase housing capacity for discharge to the community and offer psychosocial	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£20,100	£37,347	100%
77	Outreach Service	Kings Outreach Therapy Service (KCH led across Lambeth & Southwark) (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£153,711	£285,601	100%
78	Pathway 2 & 3 Discharges	Placements, hotels, equipment inc homeless and NRPF (24/25 subject to review)	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		10	0	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£350,000	£650,313	100%
79	Pathway 2 & 3 Discharges	Placements, and bed based intermediate care (24/25 subject to review)	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		3	0	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£150,000	£278,705	100%

80	Pathway 2 & 3 Discharges	Placements, and bed based intermediate care (24/25 subject to review)	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		6	0	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£468,689	£870,841	100%
81	Homeless discharge service	Accommodation and support to enable discharge of homeless patients ready for discharge (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£196,000	£364,175	100%

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. 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 social 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 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. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. 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. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 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.
16	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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Southwark

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	234.0	196.7	236.8	205.0	The ambition is for a 5% reduction in 23/24, reflecting a continuation of progress made in 22/23. Benchmarking suggests this is achievable given 22/23 position is top quartile for London, and if key conditions such as COPD, heart failure,asthma & diabetes can be managed more in the community. Note Q4 actual 22/23 rate 205 in line with target.	A range of BCF services and related partnership improvement workstreams directly and indirectly support the objective of reducing avoidable admissions. e.g. Urgent Community Response, Self-Management, Age Well, neighbourhood working and PCN development, Core 20+5, Vital 5, SDEC, primary care access, risk stratification, long term condition management including diabetes and hypertension mgt, anticipatory/ proactive care.	Yes
	Number of Admissions	502	422	508	-			
	Population	318,830	318,830	318,830	318,830			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	222	187	225	195			Yes

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,299.0	1,940.0	1,843.0	Draft proposal is for a 5% annual reduction in falls admissions which benchmarking suggests is achievable given the 21/22 rate was around 5% above the London average and draft data suggests on course for delivering a 5% reduction on 21/22. Waiting for 22/23 falls data from BCF team before finalising.	Falls prevention is a key focus of the Partnership Southwark Age Well frailty workstream and agencies working with older people are focussed on this objective. The GSTT community falls service is funded from the BCF. Services such as ICES and telecare have a strong falls prevention/admission element.	Yes
	Count	560	473	450			Yes
	Population	25,997	25997	25997			Yes

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	96.5%	96.9%	96.9%	97.1%	Benchmarking shows that Southwark had the highest rate on this measure in London in 22/23. This reflects very strong services that support a home first approach. The 96.8% target reflects a continuation of this high level of performance. A target to further increase the rate is not considered appropriate as current performance is optimal.	The BCF continues to fund the provision of high intensity home based support services enabling an effective and safe home first approach in the vast majority of discharges from hospital. For example, home based reablement and intermediate care, intensive home care, double handed care, overnight home care.	Yes
	Numerator	5,009	4,883	5,070	5,098			
	Denominator	5,189	5,041	5,230	5,252			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	96.8%	96.8%	96.8%	96.8%			
	Numerator	5,571	5,344	5,343	5,201			Yes
	Denominator	5,755	5,521	5,520	5,373			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	562.0	538.8	498.9	539.7	The target is 22/23 planned activity and 4% increase to reflect the population and acuity. Target challenging as dealing with increasing complexities and must ensure forecasting accommodates those sudden fluctuations and the long term impact of	To maintain people's independence in the community as long as possible using care packages and reablement.	Yes
	Numerator	157	162	150	169			Yes
	Denominator	27,938	30,064	30,064	31,312			

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

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.6%	83.0%	92.4%	90.0%	Taking into account long term trends in this data it is considered that 90% reflects optimal performance and is a stretching target to maintain. Benchmarking data supports this, with only 3 Inner-London boroughs above 90%. Although the 2022/23 level was slightly higher this is viewed as a "blip". We do not predict it will continue to rise taking into account the range of needs levels of referrals being accepted into the service. The needs of those discharged from hospital varies and figures can be affected by only a handful of complex cases, and it is to be expected that a proportion of these will not hit the target.	Streamlining care and support via the new transfer of care team (new team that transfers patients from hospital to home). Intermediate Care Southwark working hard to ensure the right people receive reablement at the right time.	Yes
	Numerator	161	760	871	849			Yes
	Denominator	186	916	943	943			Yes

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

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

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Southwark

	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	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 all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* 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? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes		The plan will be presented to the Health and Wellbeing Board meeting on 20/7/23. In the interim it was agreed with the chair that this draft, approved by senior ICB and Council lead officers, would be submitted.	20/07/2023	Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	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 integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • 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 *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes				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? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • 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? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**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 to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**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? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* 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? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**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 based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

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

5. Income

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

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

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

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

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

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

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

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

6. Expenditure

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

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

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

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme

- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

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

6. Area of Spend:

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

7. Commissioner:

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

8. Provider:

- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

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

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

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

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

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

7. Metrics

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

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

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

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

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

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

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

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

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

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

			Complete:
Health and Wellbeing Board:	Southwark		Yes
Completed by:	Adrian Ward		Yes
E-mail:	adrian.ward@selondonics.nhs.uk		Yes
Contact number:	0208 176 5349		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no please indicate when the HWB is expected to sign off the plan:	Thu 20/07/2023	<< Please enter using the format, DD/MM/YYYY	Yes

	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	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Andrew	Bland	andrew.bland@selondonics.nhs.uk	Yes
	Additional ICB(s) contacts if relevant		Martin	Wilkinson	martin.wilkinson@selondonics.nhs.uk	Yes
	Local Authority Chief Executive		Althea	Loderick	althea.loderick@southwark.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		David	Quirke-Thornton	david.quirke-thornton@southwark.gov.	Yes
	Better Care Fund Lead Official		Adrian	Ward	adrian.ward@selondonics.nhs.uk	Yes
	LA Section 151 Officer		Clive	Palfreyman	clive.palfreyman@southwark.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Southwark

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£1,686,144	£1,686,144	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£28,095,959	£29,686,191	£28,095,959	£29,686,191	£0
iBCF	£17,847,349	£17,847,349	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£1,287,225	£1,287,225	£0
Additional ICB Contribution	£1,200,520	£1,200,520	£1,200,520	£1,200,520	£0
Local Authority Discharge Funding	£2,502,171	£4,153,604	£2,502,171	£4,153,604	£0
ICB Discharge Funding	£1,599,000	£2,971,000	£1,599,000	£2,971,000	£0
Total	**£54,218,368**	**£58,832,033**	**£54,218,368**	**£58,832,033**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£7,984,075	£8,435,974
Planned spend	£8,264,564	£8,708,382

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£19,508,213	£20,612,377
Planned spend	£20,254,645	£21,401,059

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	222.0	187.0	225.0	195.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,940.0	1,843.0
	Count	473	450
	Population	25997	25997

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	96.8%	96.8%	96.8%	96.8%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	562	540

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.0%

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 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Southwark

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

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

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

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

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

3.2 Demand - Community

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

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

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

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Analysis gives best estimates, caveated due to data issues including limitations in reporting on requested data items. Rehab, UCR and at home estimates only based on last available 12 months data before system outage. Capcity and demand data to be built on during the year as community health provider implements new data system. Discharge data reflects estimated apportionment of ICB Operating Plan trajectories to borough level. Estimated 5% pathway zero receive some form of social or VCS support. Demand for intermediate care from the community for vol sector services is zero as VCS do not provide formal Intermediate Care. Short term domiciliary care / other social care incorporated into reablement. Unmet need data not available hence capacity reflects demand in baseline data and projections. Mental health not included as comparable data not available.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

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

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	42	44	44	42	43	40	44	42	39	42	39	41
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		34	36	35	34	35	32	36	34	31	33	31	33
OTHER		7	7	7	7	7	6	7	7	6	7	6	7
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Reablement at home (pathway 1)	18	21	17	11	14	32	23	36	27	26	26	39
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		14	17	14	9	11	25	19	29	22	21	21	31
OTHER		3	3	3	2	2	5	4	6	4	4	4	6
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	61	61	61	61	61	61	61	61	61	61	61	61
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		49	49	49	49	49	49	49	49	49	49	49	49
OTHER		9	9	9	9	9	9	9	9	9	9	9	9
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	1	1	1	1	1	1	1	1	1	1	1	1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	9	9	9	9	9	8	9	9	8	9	8	9
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		7	7	7	7	7	7	7	7	7	7	7	7
OTHER		1	1	1	1	1	1	1	1	1	1	1	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	10	11	11	6	8	7	10	10	7	11	9	9
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		8	9	9	5	6	5	8	8	6	9	7	7
OTHER		2	2	2	1	1	1	2	2	1	2	1	1
Totals	**Total:**	276	288	280	255	265	290	291	312	280	293	281	312

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	120	120	120	120	120	120	120	120	120	120	120	120
Reablement at home	39	56	56	35	21	17	23	29	22	22	22	12
Rehabilitation at home	54	54	54	54	54	54	54	54	54	54	54	54
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	83	87	86	82	85	79	87	82	76	82	76	81	0%	100%	0%
Reablement at Home	Monthly capacity. Number of new clients.	35	42	34	22	27	62	46	70	53	50	50	76	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	119	119	119	119	119	119	119	119	119	119	119	119	100%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2	100%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	17	17	17	17	17	17	17	17	17	17	17	17	100%	0%	0%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	20	22	22	12	15	13	20	20	14	22	17	17	100%	0%	0%

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	120	120	120	120	120	120	120	120	120	120	120	120	100%	0%	0%
Reablement at Home	Monthly capacity. Number of new clients.	39	56	56	35	21	17	23	29	22	22	22	12	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	54	54	54	54	54	54	54	54	54	54	54	54	100%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Southwark

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Southwark	£1,686,144	£1,686,144	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£1,686,144**	**£1,686,144**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Southwark	£2,502,171	£4,153,604	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS South East London ICB	£1,599,000	£2,971,000	Yes
Total ICB Discharge Fund Contribution	£1,599,000	£2,971,000	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Southwark	£17,847,349	£17,847,349	Yes
Total iBCF Contribution	**£17,847,349**	**£17,847,349**	

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

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
Southwark	£1,287,225	£1,287,225	Council's core budget	Yes
Total Additional Local Authority Contribution	**£1,287,225**	**£1,287,225**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS South East London ICB	£28,095,959	£29,686,191
Total NHS Minimum Contribution	**£28,095,959**	**£29,686,191**

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

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
NHS South East London ICB	£1,200,520	£1,200,520	Additional ICES budget	Yes
Total Additional NHS Contribution	**£1,200,520**	**£1,200,520**		
Total NHS Contribution	**£29,296,479**	**£30,886,711**		

	2023-24	2024-25
Total BCF Pooled Budget	**£54,218,368**	**£58,832,033**

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

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Southwark

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£1,686,144	£1,686,144	£0	£1,686,144	£1,686,144	£0
Minimum NHS Contribution	£28,095,959	£28,095,959	£0	£29,686,191	£29,686,191	£0
iBCF	£17,847,349	£17,847,349	£0	£17,847,349	£17,847,349	£0
Additional LA Contribution	£1,287,225	£1,287,225	£0	£1,287,225	£1,287,225	£0
Additional NHS Contribution	£1,200,520	£1,200,520	£0	£1,200,520	£1,200,520	£0
Local Authority Discharge Funding	£2,502,171	£2,502,171	£0	£4,153,604	£4,153,604	£0
ICB Discharge Funding	£1,599,000	£1,599,000		£2,971,000	£2,971,000	£0
Total	**£54,218,368**	**£54,218,368**	**£0**	**£58,832,033**	**£58,832,033**	**£0**

Required Spend

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

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,984,075	£8,264,564	£0	£8,435,974	£8,708,382	£0
Adult Social Care services spend from the minimum ICB allocations	£19,508,213	£20,254,645	£0	£20,612,377	£21,401,059	£0

Checklist

Column complete:

Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

										Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Enhanced Intervention Services - ICB	MDT providing enhanced psycholgical support for people with learning disabilities and challenging behaviour	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution	Existing	£228,404	£241,331	100%
2	Admissions avoidance - ERR and @home	Community health services enhanced rapid response and @home service	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		2100	2100	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£5,044,499	£5,330,018	49%
3	GP Support @ Home Acuity	Service provides acute clinical care @ home. Multidisciplary team providing quality care at the persons ow home	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£264,654	£279,633	3%
4	@Home Geriatric Assessment	Service providing geriatric assessment and advance care planning in a persons own home	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£31,320	£33,093	0%
5	@Home Integrated Care Fellows	At home integrated Clinical Care Fellows expertise	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£86,130	£91,005	1%
6	Falls service	Southwark community rehab and falls service: specialising in preventing falls, supporting people who have previously had	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£856,949	£905,452	54%
7	Occupational Therapy-Southwark	OT working with falls service supporting people who after an injury or illness have functional, cognitive and phsychological	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£48,936	£51,706	39%
8	Tissue Viability - Community	Service providing treatment, advice and education on treatment of wounds and pressure ulcers in community	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£58,415	£61,722	39%
9	Therapies - Foot Health Community	Assess, treat and advise people with foot conditions. Podiatrists who support foot and lower limb care.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£65,489	£69,195	39%
10	Palliative Care @ Home	Service provides palliative nursing care at home, also support for families of people who are seriously ill.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£326,236	£350,360	29%
11	Self-management	Self-management for people with long term conditions	Prevention / Early Intervention	Other	Self-management courses/resource				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£163,031	£172,259	100%
12	EIS - Speech & Language Therapist	GSTT therapist working in EIS team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£65,133	£68,820	100%
13	Neuro-rehab team - GSTT	Support workers for GSTT community neuro-rehab team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£205,691	£217,333	100%
14	Community Equipment Service	ICES Contract - CCG costs - BCF additional contribution	Assistive Technologies and Equipment	Community based equipment		2862	3120	Number of beneficiaries	Community Health		NHS			Private Sector	Additional NHS Contribution	Existing	£1,200,520	£1,200,520	100%
15	Community Equipment Service	ICES Contract - CCG costs - BCF core contribution	Assistive Technologies and Equipment	Community based equipment		807	880	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£296,427	£313,205	100%
16	Behavioural Support - LD and autism	Community team	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
17	Dementia - Enhanced Neighbourhood	Integrated Care Planning and Navigation	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£184,177	£184,177	53%
18	Homecare Quality Improvement	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		107309	113699	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,114,000	£2,330,840	11%

19	Residential & Nursing	Residential and Nursing Placements	Residential Placements	Care home		55	55	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,691,939	£2,943,455	12%
20	Protect Adult Social Care - Residential Care	Residential Care	Residential Placements	Care home		48	48	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,254,877	£2,479,452	22%
21	Mobilisation - Intermediate and Nursing Care	Nursing and reablement placements	Residential Placements	Care home		2	2	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	New	£100,000	£100,000	1%
22	Discharge to Assess - Council Costs	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£540,600	£573,036	100%
23	Reablement - OT Team ICS	Intermediate Care Services	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£467,250	£490,613	100%
24	Hospital discharge Team	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,879,976	£1,973,974	90%
25	Housing Worker Discharge Team	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
26	Intermediate Care	Intermediate Care Services	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		300	300	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,205,817	£1,278,166	84%
27	Night Owls - overnight intensive	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		13000	13000	Hours of care	Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution	Existing	£241,000	£241,000	99%
28	Reablement Team	Intermediate Care Services	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		525	525	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,033,575	£2,135,254	100%
29	Community Mental Health Services	Community Based Schemes	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£694,300	£735,958	61%
30	Enhanced Psychological Support for those	LD clients	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£29,000	£29,000	5%
31	Learning Disability - Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£223,660	£237,080	6%
32	Mental Health Reablement	Community Based Schemes	Reablement in a persons own home						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£160,730	£170,374	8%
33	Mental Health - Personal Budgets	Personalised Budgeting and Commissioning	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£636,000	£674,160	42%
34	Mental Health Broker	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£63,000	£66,150	100%
35	Mental Health Complex Cases Worker	Community Based Schemes	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
36	Mental Health Discharge Worker	HICM for Managing Transfer of Care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£52,500	£55,125	100%
37	Psychiatric Liaison (AMHPs and reablement)	Community Based Schemes, admissions avoidance	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£315,000	£330,750	36%
38	Care Act Funding	Care Act Implementation Related Duties	Care Act Implementation Related Duties	Other	Carers				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,000,000	£1,000,000	100%
39	Service Development and Change	Funding for integration projects	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£45,000	£45,000	4%
40	Carers Strategy	Carers Services	Carers Services	Respite services		125	125	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£450,000	£450,000	87%
41	Unpaid Carers	Support for carers of people with dementia	Carers Services	Respite services		30	30	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£100,000	£100,000	100%
42	Community Equipment	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		250	280	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£562,000	£562,000	22%
43	Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		98	105	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£623,995	£623,995	59%
44	Voluntary Sector Prevention Services	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		Joint	28.0%	72.0%	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,081,251	£1,081,251	87%
45	Voluntory Sector Carers work	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£400,000	£400,000	100%
46	iBCF funding plans - home care	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		523990	521608	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£10,327,850	£10,327,850	42%
47	iBCF funding plans - nursing care homes	Residential Placements	Residential Placements	Nursing home		79	79	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£4,174,334	£4,174,334	17%
48	iBCF funding plans - Transformation fund to improve	Community Based Schemes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	iBCF	Existing	£250,000	£250,000	100%
49	IBCF Reablement and Intermediate bed based care	Intermediate Care Services	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement accepting step up and step down users		151	151	Number of Placements	Social Care		LA			Private Sector	iBCF	Existing	£999,749	£999,749	100%

50	Residential care for older people	Residential Placements	Residential Placements	Care home		8	8	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£400,000	£400,000	2%
51	Nursing Care for older People	Residential Placements	Residential Placements	Nursing home		6	6	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£300,000	£300,000	3%
52	Home care for older people	Home Care or Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages		44420	44083	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£870,648	£870,648	4%
53	Flexicare - Housing Based Scheme	Extracare - Flexi-care	Residential Placements	Extra care		22	22	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£524,768	£524,768	24%
54	Disabled Facilities Grants	DFG Related Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		150	150	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£1,686,144	£1,686,144	100%
55	Community Equipment	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Community based equipment		250	280	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£246,850	£246,850	10%
56	Telecare	Assistive Technologies and Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		98	105	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£444,626	£444,626	42%
57	Voluntary Sector Prevention Services	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£482,749	£482,749	39%
58	Voluntory Sector Carers work	Prevention / Early Intervention	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£113,000	£113,000	28%
59	Further investment into Nursing Care	Further investment into the Nursing Care sector (24/25 subject to review) to allow for a new care home within the borough to	Residential Placements	Nursing home		22	22	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£713,000	£1,183,580	3%
60	Improvements in Reablement Outcomes	Further investment into reablement packages to improve outcomes (24/25 subject to review). This would increase the	Home-based intermediate care services	Reablement at home (to support discharge)		44	44	Packages	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£200,000	£332,000	10%
61	Enhanced resources into Homecare	Enhanced investment into double handed care placements (24/25 subject to review) to allow for more effective discharge to an "at	Home Care or Domiciliary Care	Domiciliary care packages		9238	9328	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£220,673	£366,317	1%
62	Maximising the use of Extra Care and sheltered	Investment in Extra Care Housing, Sheltered and Alms housing (24/25 subject to review) to facilitate higher acuity discharges from	Housing Related Schemes						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£77,000	£127,820	4%
63	Residential Care Charter	Accelerated investment in to the LA's in-borough provider's (24/25 subject to review) in providing a supplement which would	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£150,000	£249,000	50%
64	Hospital Buddies	Supports to those who are due to be admitted to hospital for elective surgery, with discharge preparation (24/25 subject to	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£20,000	£33,200	100%
65	Double Handed Care	Occupational Therapist based in the ToC Review team (24/25 subject to review) to look at all new residents being discharged	Other						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£55,000	£91,300	100%
66	Transfer of Care Assessment Team	Community based team to complete assessments in the community as a part of the D2A model to facilitate quick and safe	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£175,000	£290,500	10%
67	Cost of Living Crisis Worker	Non-qualified staff member to support people who are due to be discharged from Hospital or recently discharged with the	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£35,000	£58,100	100%
68	Step Down Flats	To fund 7 step down flats in extra care sheltered housing. (24/25 subject to review).This will enable pathway 1	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support discharge)		35	35	Number of Placements	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£188,998	£313,737	25%
69	Increased Brokerage Support	This additional funding helped to provide the right care and the right time for the right people and speed up pathway 1 and 3	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£27,500	£45,650	4%
70	Retention initiative for OT Workers	Investment into earmarked initiative for Occupational Therapists retention payment to assist in retaining staff please. (24/25	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£40,000	£66,400	0%
71	Further Investment into Residential Care	Further investment into the Residential Care sector (24/25 subject to review) to allow for a new provider within the borough to	Residential Placements	Care home		11	11	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	New	£600,000	£996,000	2%
72	Mental Health Discharge Housing Workers	MH Discharge workers to support MFFD homeless on the ward and those currently in B&B. (24/25 subject to review). Facilitate	Housing Related Schemes						Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£40,000	£74,321	100%
73	Expand step down housing	Step down flats (24/25 subject to review) - Create capacity in complex care placement for MFFD patients currently on the ward	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement (to support discharge)		48	0	Number of Placements	Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£144,500	£268,486	100%
74	Expand step down housing options	Placement review workers (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£36,000	£66,889	100%
75	Additional Home Treatment Team (HTT) capacity	HTT advanced practitioners to support individuals discharged to step down accommodation (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£40,000	£74,321	100%
76	Shared lives support	Step down service for people discharged from hospital. (24/25 subject to review). Increase housing capacity for discharge to the community and offer psychosocial	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£20,100	£37,347	100%
77	Outreach Service	Kings Outreach Therapy Service (KCH led across Lambeth & Southwark) (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£153,711	£285,601	100%
78	Pathway 2 & 3 Discharges	Placements, hotels, equipment inc homeless and NRPF (24/25 subject to review)	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		10	0	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£350,000	£650,313	100%
79	Pathway 2 & 3 Discharges	Placements, and bed based intermediate care (24/25 subject to review)	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		3	0	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£150,000	£278,705	100%

80	Pathway 2 & 3 Discharges	Placements, and bed based intermediate care (24/25 subject to review)	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with rehabilitation (to support admission avoidance)		6	0	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£468,689	£870,841	100%
81	Homeless discharge service	Accommodation and support to enable discharge of homeless patients ready for discharge (24/25 subject to review)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£196,000	£364,175	100%

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. 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 social 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 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. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. 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. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 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.
16	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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Southwark

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	234.0	196.7	236.8	205.0	The ambition is for a 5% reduction in 23/24, reflecting a continuation of progress made in 22/23. Benchmarking suggests this is achievable given 22/23 position is top quartile for London, and if key conditions such as COPD, heart failure,asthma & diabetes can be managed more in the community. Note Q4 actual 22/23 rate 205 in line with target.	A range of BCF services and related partnership improvement workstreams directly and indirectly support the objective of reducing avoidable admissions. e.g. Urgent Community Response, Self-Management, Age Well, neighbourhood working and PCN development, Core 20+5, Vital 5, SDEC, primary care access, risk stratification, long term condition management including diabetes and hypertension mgt, anticipatory/ proactive care.	Yes
	Number of Admissions	502	422	508	-			
	Population	318,830	318,830	318,830	318,830			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	222	187	225	195			Yes

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,299.0	1,940.0	1,843.0	Draft proposal is for a 5% annual reduction in falls admissions which benchmarking suggests is achievable given the 21/22 rate was around 5% above the London average and draft data suggests on course for delivering a 5% reduction on 21/22. Waiting for 22/23 falls data from BCF team before finalising.	Falls prevention is a key focus of the Partnership Southwark Age Well frailty workstream and agencies working with older people are focussed on this objective. The GSTT community falls service is funded from the BCF. Services such as ICES and telecare have a strong falls prevention/admission element.	Yes
	Count	560	473	450			Yes
	Population	25,997	25997	25997			Yes

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	96.5%	96.9%	96.9%	97.1%	Benchmarking shows that Southwark had the highest rate on this measure in London in 22/23. This reflects very strong services that support a home first approach. The 96.8% target reflects a continuation of this high level of performance. A target to further increase the rate is not considered appropriate as current performance is optimal.	The BCF continues to fund the provision of high intensity home based support services enabling an effective and safe home first approach in the vast majority of discharges from hospital. For example, home based reablement and intermediate care, intensive home care, double handed care, overnight home care.	Yes
	Numerator	5,009	4,883	5,070	5,098			
	Denominator	5,189	5,041	5,230	5,252			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	96.8%	96.8%	96.8%	96.8%			
	Numerator	5,571	5,344	5,343	5,201			Yes
	Denominator	5,755	5,521	5,520	5,373			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	562.0	538.8	498.9	539.7	The target is 22/23 planned activity and 4% increase to reflect the population and acuity. Target challenging as dealing with increasing complexities and must ensure forecasting accommodates those sudden fluctuations and the long term impact of	To maintain people's independence in the community as long as possible using care packages and reablement.	Yes
	Numerator	157	162	150	169			Yes
	Denominator	27,938	30,064	30,064	31,312			

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

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.6%	83.0%	92.4%	90.0%	Taking into account long term trends in this data it is considered that 90% reflects optimal performance and is a stretching target to maintain. Benchmarking data supports this, with only 3 Inner-London boroughs above 90%. Although the 2022/23 level was slightly higher this is viewed as a "blip". We do not predict it will continue to rise taking into account the range of needs levels of referrals being accepted into the service. The needs of those discharged from hospital varies and figures can be affected by only a handful of complex cases, and it is to be expected that a proportion of these will not hit the target.	Streamlining care and support via the new transfer of care team (new team that transfers patients from hospital to home). Intermediate Care Southwark working hard to ensure the right people receive reablement at the right time.	Yes
	Numerator	161	760	871	849			Yes
	Denominator	186	916	943	943			Yes

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

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

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Southwark

	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	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 all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* 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? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes		The plan will be presented to the Health and Wellbeing Board meeting on 20/7/23. In the interim it was agreed with the chair that this draft, approved by senior ICB and Council lead officers, would be submitted.	20/07/2023	Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	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 integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • 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 *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes				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? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • 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? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	PR4	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	PR5	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				Yes
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**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 to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes				Yes

Agreed expenditure plan for all elements of the BCF	**PR8**	**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? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* 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? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes				Yes
Metrics	**PR9**	**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 based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes				Yes

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HEALTH AND WELLBEING BOARD AGENDA DISTRIBUTION LIST (OPEN)
MUNICIPAL YEAR 2023-24

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Councillor Maria Linforth Hall	1	Maria Lugangira, Constitutional Team	2
Anood Al-Samerai	1		
Sarah Austin	1		
David Bradley	1		
Cassie Buchanan	1		
Sheona St Hilaire	1	**Total:**	19
Clive Kay	1		
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Sangeeta.Leahy	1		
Alasdair Smith	1		
David Quirke-Thornton	1		
Martin Wilkinson	1		
James Lovell	1		
		Dated: July 2023	