Public Document Pack

Health & Wellbeing Board Supplementary Agenda

4. **Urgent Business (if any)** (Pages 3 - 46)

Better Care Fund Plan 2021-22

This document sets out Croydon's Better Care Fund Plan for 2021-22.

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REPORT TO:	**HEALTH & WELLBEING BOARD** **19 January 2022**
SUBJECT:	**Better Care Fund 2021-22**
LEAD OFFICER:	**Annette McPartland** **Interim Corporate Director Adult Social Care & Health (DASS)** **Rachel Flagg** **Director of Transformation and Commissioning** **Croydon Health Services and SWL CCG (Croydon**
ORIGIN OF ITEM:	
BRIEF FOR THE COMMITTEE:	In order to ensure that the governance is completed, we now wish to complete approval by bringing the BCF plan 2021-22 to Health and Wellbeing Board for ratification.

1. EXECUTIVE SUMMARY

1.1 This document sets out Croydon's Better Care Fund Plan for 2021-22

1.2 The Board has the opportunity to discuss the contents within the report.

2. BETTER CARE FUND PLAN

2.1 **The Better Care Fund**
The proposed plan is attached at **Appendix 1.**

2.2 **Summary**
The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires clinical commissioning groups (CCGs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

Given the ongoing pressures in systems from COVID-19, there were minimal changes made to the BCF in 2021 to 2022. The 2021 to 2022 Better Care Fund policy framework build on progress during the COVID-19 pandemic,

strengthening the integration of commissioning and delivery of services and delivering person-centred care, as well as continuing to support system recovery from the pandemic

The accompanying plan, which has been jointly created by Health & Social Care and was signed off by the One Croydon Senior Executive Group in November 2021, was unable to be completed in a more planned way at the start of the year due to the late guidance provided by the NHS. As such partners have been put into a situation where we have been unable to seek approval for the plan from the Health and Wellbeing Board in line with current scheduled meetings before the plan was required to be submitted.

Hence approval by the chair of the Health and Wellbeing Board was sought and provided on the 16th December 2021, in order to obtain the sign-off required for award of the Better Care Fund plan before the next board meeting on 19th January 2022.

In order to ensure that the governance is completed, we now wish to complete approval by bringing this to Health and Wellbeing Board for ratification.

3 RECOMMENDATIONS

3.1 The Board is recommended ratify the Better Care Fund Plan.

CONTACT OFFICER:

BACKGROUND DOCUMENTS: None

APPENDIX 1: Better Care Fund Plan Report

Cover

Health and Wellbeing Board(s):

CROYDON

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

How have you gone about involving these stakeholders?

This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care.

Bodies involved include:

- SW London Clinical Commissioning Group (Croydon Borough)
- London Borough of Croydon
- Croydon Health Services
- Age UK Croydon
- South London and Maudsley NHS FT
- Croydon GP Collaborative.
- Local Care agencies, including care providers and care homes

Stakeholders have been involved via the One Croydon Alliance groups such as: the BCF working group, Localities Board, The Commissioning and Population health Management group and the Senior executive Group. This has included colleagues from Health, Social Care, Housing and DFG.

1.0 Executive Summary

This should include:

- *Priorities for 2021-22*
- *key changes since previous BCF plan*

This document sets out Croydon's Better Care Fund Plan for 2021-22. It complements the BCF Planning Template which will be submitted together with this narrative.

This BCF narrative document and the Planning template will show that Croydon BCF plan for 2021-22:

1- Has been jointly agreed between health and social care partners. This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. As outline in the next section of this document the One Croydon Governance has been used to agree the plan.
2- Includes a contribution to adult social care from the NHS in line with the required minimum contribution. This is approximately £10.7M which is the minimum requirement.
3- Includes a large proportion of NHS commissioned schemes delivered out of hospital. Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £15.9, this being well in excess of the mandated minimum of £7.89M.
4- Makes a significant contribution to support people achieving better outcomes following discharge from hospital. This is both through a programme of improvement of discharge processes from hospital and of Discharge to Assess in the community, which in Croydon has been established since 2017.

As such, our plan meets the BCF national conditions, which were set out in the Planning Requirements published on 30 September 2021.

Our joint priorities are outlined in section 3 ("Overall approach to Integration"). Our plan for 2021-22 builds upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS partners, the Voluntary Sector, Mental Health and social care which outlines a vision for how health and social care will be delivered across the borough, particularly for those with the greatest need, to transform the health and wellbeing of local people. The plan emphasises three clear priorities:

- Focus on prevention and proactive care: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early.
- Unlock the power of communities: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer.
- Develop services in the heart of the community: giving people easy access to joined up services that are tailored to the needs of their local community

In Croydon, we are implementing this plan via the One Croydon Alliance, which is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning to improve the lives of older people in Croydon. The Partners in this Alliance are: Croydon council, SW London CCG (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust and Age UK Croydon.

In 2014, Croydon Council and Croydon Clinical Commissioning Group (now SW London CCG) recognised they faced a common challenge to improve services for older people in an environment where demand was increasing, and resources were reducing. They agreed to work together to establish an Outcome Based Commissioning (OBC) framework to develop services for people over 65.

In April 2017, local partners formed an Alliance and signed a 1-year transition plan (the Croydon Alliance Agreement) which was followed by a further 9-year extension signed in March 2018. Initially, the Alliance focused on older people and developed the Living Independently for Everyone (LIFE) service as well as setting up the GP Practice based Multi-Agency Huddles and Telemedicine in Care Homes. The Alliance has now extended its work to all adults and the direction of travel is that eventually the whole population will be in scope for Alliance working.

The Alliance vision is to support the people in Croydon to be independent and live longer, healthier and fulfilling lives and be able to access high quality care, in the right place and at the right time, thereby reducing health inequality in Croydon. The aim is to achieve this vision while realising financial sustainability in the system and maintaining improved outcomes.

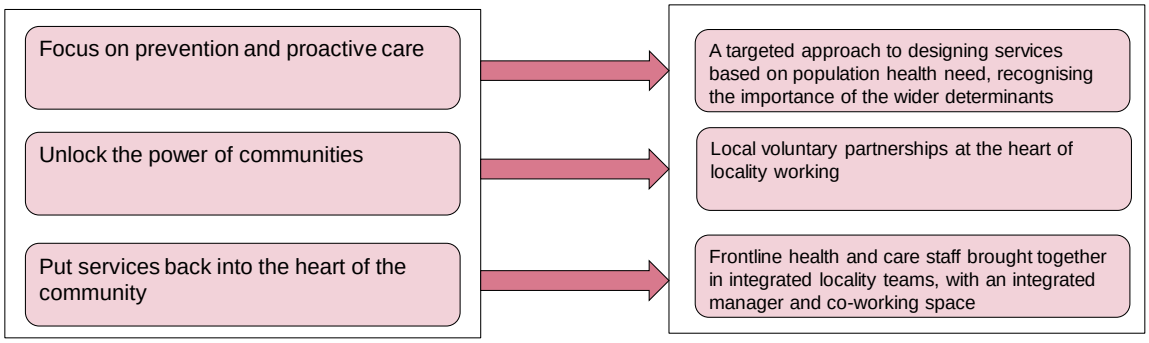
Previous BCF plans for Croydon focused on delivery of improved integrated community services that enabled people to receive the care they need at home or close to home. In so doing, reduce demand on acute health services and help maintain their independence and, as a consequence, reduce dependence on statutory services. These services included:

- Multi-Agency Huddles (including social workers) which are practice based
- LIFE service (Living Independently for Everyone)
- Community Diabetes Service
- Falls Service
- Community Based COPD Service
- Community Based Cardiology Service
- Accessible Mental Health Service
- Mental Health Reablement
- End-of-life care

All these service initiatives were supported through a range of other enabling projects including assistive technology, carer support, housing service, as well as additional social work support in working with the hospital to avoid admission to hospital through emergency care and facilitate timely and safe discharges.

Most of the BCF schemes in 2021-22 have been rolled over from 2020-21 but the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 and feed into the Localities Programme of integration in Croydon.

We have built on previous plans to take into account the increased emphasis on maximising independence and outcomes for people discharged from hospital via our Croydon LIFE service. As well as the development of our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon. This is a major programme of transformation and integration that will improve outcomes for Croydon people through a proactive and preventative approach within each of the localities of the borough. One Croydon partners committed to a locality approach via ICN+ as a flagship initiative within our Croydon Health and Care Plan, which aims to deliver the three key objectives, as below.



We are also strengthening Frailty as a key area of work through BCF funding and ICN+, by developing a strategy that will join up acute frailty care with frailty care in the community.

The BCF and One Croydon Programme are the strong foundations for integrated care in Croydon and help us deliver on our strategic commitments on the sustainability of Croydon's health and care services, delivering care where our population needs it and encouraging healthy lifestyles, as well as recognising the need within our transformational work to reduce avoidable hospital admissions and hospital length of stay (see section called "Supporting Discharge").

2.0 Governance

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

With the introduction of the One Croydon Alliance whole system groups, including that of the Commissioning, planning & PHM group, has allowed One Croydon the opportunity to strengthen the BCF management and oversight. In order to maximise the opportunity new governance has been installed, that have made the below amendments to the BCF S75 as well as the appropriate Terms of Reference.

BCF Executive Group & SEG:

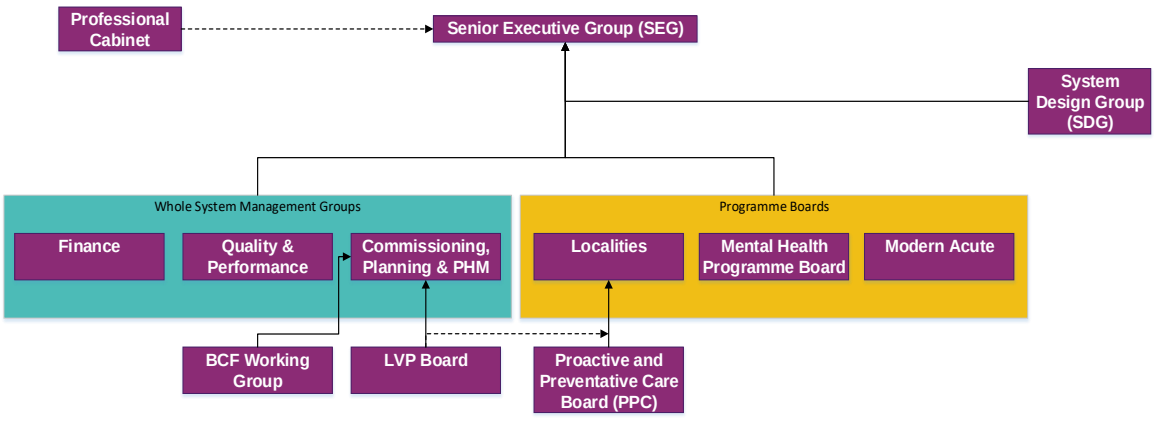
Under the previous S75 agreement, final BCF signoff was to be completed by the BCF executive board. However, as the key members of this executive board already sit within the Senior Executive Group (SEG), within the current one Croydon governance it was proposed and agreed that the BCF executive boards functions are subsumed into SEG. SEG reports into the Shadow Health and Care Board, which feeds into to the Croydon Health and Wellbeing Board.

The role of the Commissioning, Planning and PHM:

With the introduction of the Commissioning, planning & PHM group, there now exists a governing board that can apply oversight to BCF requests and Proposals prior to final agreement by SEG. Although not responsible for drafting proposals the group will now be responsible for discussing and approving proposals with all relevant One Croydon professionals.

Introduction of the BCF working group:

To facilitate the process of reviewing, planning and developing BCF spend options, a new BCF working group has been formed by commissioners and finance personal from health and social care. This group will report to the Commissioning, planning & PHM group quarterly with all reviews, options and proposed changes prior to any final submission.



This was approved by Senior Executive Group on the 5th October 2021.

3.0 Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- *Joint priorities for 2021-22*
- *Approaches to joint/collaborative commissioning*
- *Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.*
- *How BCF funded services are supporting your approach to integration.*

Briefly describe any changes to the services you are commissioning through the BCF from 2020-21

Joint Priorities and the Croydon Health and Care Plan

Croydon established a 'Place based partnership' back in 2017 through the One Croydon Alliance. Moving forward and with the introduction of the ICS, Place-based partnerships will remain as the foundations of integrated care systems building on existing local arrangements and relationships. Place has four main roles, all of which One Croydon has been delivering since 2017:

- To support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods.
- To simplify, modernise and join up health and care
- To understand and identify people and families at risk of being left behind and to organise proactive support for them; and
- To coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

In 2019, One Croydon launched a five-year Health and Care plan to help people in our community improve their health and wellbeing. Following 2020/21 and the COVID-19 pandemic a new refreshed plan was needed as a response from health and social care. This refresh has given One Croydon the opportunity to come together and assess our progress so far and what our priorities need to be in a fast-changing environment including emerging impact of the pandemic, the Health and Care Bill and the Local Authority financial position.

As such, additional aims for 2021 to 2023 have been included:

- Support Croydon people to recover from the effects of the pandemic, through the recovery programme and a focus on high quality care
- Support, develop and maintain the Croydon health and care workforce
- Lead a determined, collaborative approach to tackling inequalities
- Embed a Population Health Management Approach

Approach to collaborative commissioning

In the last year we have strengthened our collaborative commissioning work between the Council and the CCG.

One example is the recommissioning of the BCF funded End of Life Respite service. This is commissioned by the CCG. The aim of this service is to supports people to die at home if

that is their preferred place of death whilst reducing the risk of A&E/Hospital admission if a carer enters a crisis.

The contract ended on 30st September 2021. The CCG team in Croydon worked closely with the Council team to undertake a mini-tender for a new contract to begin on 1st October using the Council's Dynamic Purchasing System (DPS 1) to procure a new service. The evaluation panel was clinically led and involved 2 GPs, as well as colleagues from the Council, CCG and procurement team. The mini tender was successful, and a new provider identified. This was the first time the CCG used the Council's DPS for procuring a service collaboratively.

Placement is another area where there have been good opportunities for collaborative working. Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. The Council and the CCG's CHC team are working in partnership to develop the Care Home market, especially Nursing Homes. A few examples of how we work collaboratively in commissioning include:

- Establishing a Care Home Strategy Group with key partners including Council, CHC, CCG and other health partners.
- CHC supporting and placing residents on D2A pathway 3 into Nursing Homes
- Looking at market trends for ongoing commissioning pathways
- Providing dedicated support and training to care homes through various mechanisms including dedicated webpages, webinars, training sessions, recruitment campaigns etc.
- Supporting around commissioning of intermediate care beds (BCF funded).

Approach to support people to remain independent at home

As in previous years and building on the work of the One Croydon Alliance to deliver the ambitions of the Croydon Health and Care Plan, we want people to continue to experience well-co-ordinated care and support in the most appropriate setting, which is truly person-centred and helps them to maintain their independence. The overarching approach to integration continues to be via the development of integrated care services that:

- help people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates.
- help to keep people with one or multiple long term conditions and complex needs stable.
- allow people to get timely and high quality access to care when they are ill, delivered in the community where appropriate;
- support people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home
- provide people who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission and promote independence
- support and provides education to both family and carers to ensure their health and well- being needs are met, and includes support to maintain finances and staying in work, where relevant
- help people requiring end of their life care to be supported to receive their care and to die in their preferred place.

There are two key programmes funded through BCF that deliver these ambitions.

ICN+

Our One Croydon flagship programme, the Integrated Community Network Plus Programme, has established an integrated community health and social care service comprising services from across Adult Social Care, Croydon Health Services, Mental Health and the voluntary sector within each locality. The integrated teams enable information sharing, joint assessment and care management. The service model ensures a one name, one budget one team approach, use of an agreed single eligibility assessment and review process, and increased entry pathways - all working to the same key outcomes.

Services under ICN+ localities are as follows:

- Community nursing
- Adult social care over 65s
- Adult social care under 65s
- Therapy services
- Age UK Personal Independence Coordinators (PICs)
- Mental Health PICs
- Named person for smaller community services e.g. Diabetes
- Link with Housing and other Council services

The ICN+ model aims to support people to stay well rather than treat them when they become sick. It focuses on preventing people developing long term conditions, such as diabetes or depression. If people have a condition, we work with them to stop it from becoming worse, thus reducing the number of avoidable hospital admissions. We recognise that physical health and mental health go hand in hand. Therefore, if we focus on preventing people from becoming lonely and social isolated, we will support them to stay independent and healthy.

Alongside rolling out the new team, access to support is also be available via Community Hubs, formerly known as “Talking Points” in the community. Health, social care and voluntary sector staff attend the Community Hubs to provide the required support.

The strength based, community-led support approach is adopted by all staff at the Community Hubs. Staff talk to people about what is important to them and explain what assets are available within local community to support them. The Community Hubs also provide advice about healthy living, housing and benefits. There is also access to a social prescriber and ongoing support from our well-established Personal Independence Service provided by Age UK croydon.

LIFE

The Croydon LIFE service established in 2017 continues to provide short term support to individuals to retain or regain their independence, at times of change and transition, which promotes the health, well-being, independence, dignity and social inclusion of the individuals who are referred to the Service. LIFE is the key service that delivers Discharge to Assess pathways in Croydon.

The service has established a highly responsive integrated intermediate care service across the borough, comprising of re-ablement, rehabilitation and other support services. The service brings together and develops the following existing services from Adult Social Care, Croydon Health Services Community Services and the Voluntary Sector:

- Community Re-ablement

- Re-ablement following hospital discharge
- Age UK Croydon Re-ablement support workers
- Rapid Response
- Community Intermediate Care Service, including home base and bedded step up/step down
- A&E Liaison
- Occupational Therapy
- Assistive technologies, comprising Telehealth and community equipment

The health and social care is delivered in a seamless, timely and holistic way in the community through an assessment of whether the service user has a physical, psychological or social need and whether the need is acute, long-term or a permanent change in function. The integrated service model uses an agreed single eligibility assessment and review process and increased entry pathways, all working to the same key outcomes. The service contributes to reductions in systems duplication, in non-elective hospital admissions and bed days.

Changes to previous BCF plans

Most of the BCF schemes funded in 21-22 have rolled over from 20-21. The ethos however has been to build on the integration work that Croydon has implemented since 2017 through the One Croydon Alliance of health and care. The schemes feed into, and enhance much of the ICN+ programme of integration and the six localities in Croydon. Much of the iBCF schemes have also refocused on packages of care to support reablement and Discharge to Assess.

All adults in Croydon (>18) are in scope for our initiatives. Frailty is an area of work that through BCF funding we are strengthening, by developing a joined up approach between acute and community frailty services.

Challenges to integration

Some of the key challenges we are facing for integration are:

- the ability for Health services and Council services to integrate IT systems to allow systems to communicate securely and allow for data interoperability
- Wider system pressures, including relatively high bed occupancy in hospital and sustained increased hospital discharges, with additional costs on packages of care
- Risks to the delivery of BCF plans due to the already challenging financial position of Croydon Council
- Workforce recruitment, retention and wellbeing. The pandemic has put sustained pressures on staff in health and care, compounded by shortages of qualified professionals
- Estates. There are many examples of integrated teams working together. However, there are issue in Croydon with where to put these teams. The pandemic has helped facilitating remote working but for effective team development having some shared spaces is important particularly for multi-agency working and relationship building.
- Covid-19 and winter pressures are expected to create extremely challenging conditions over the next few months. Many of our schemes have been very effective during the pandemic and demonstrated the power of collaborative working in getting

through a crisis. However, we cannot underestimate the risk to delivery of our ambitions due to these significant pressures.

4.0 Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

How BCF funding supports safe, timely and effective discharge

A significant proportion of the BCF funding is allocated to supporting hospital discharges via the LIFE service. As described in section 3 of this document, the LIFE service is an integrated community-based team comprising staff drawn from across health, social care and the voluntary sector. It provides intensive, proactive and goal-focused support for up to 6 weeks at times of high levels of need, when individuals require more clinical and social care interventions thereby preventing unnecessary hospital admissions or facilitating early supported discharge from a hospital ward, focussed on enabling the person back to the optimum state of wellbeing, functioning and independence (Reablement, Rehabilitation, Recovery).

As part of the One Croydon programme of work to review and improve the LIFE service, joint plans are discussed and agreed in relation to the discharge programme between CCG, LA and the local NHS Trust.

The service consists of the following elements:

1. Single integrated multidisciplinary Team - A single LIFE Team that brings together existing community services into one integrated, intermediate care, multidisciplinary team.
2. D2A pathway which includes a Trusted Assessor model, where Social Care and Therapy staff undertaking a single integrated assessment covering elements of both health and social care. The D2A model is used for all hospital discharges when care and support is required.
3. The LIFE service operates 7 days a week, 365 days a year. To support discharges from hospitals, brokerage and social workers have moved to a 6-day coverage (Mon-Sat). This is based on the pattern of discharges during the week, which shows most discharges happening on a Friday. During the height of Covid, some of the social work capacity was moved to support D2A in the community.
4. The additional hospital discharge fund has enabled Croydon to increase the capacity to assess and provide enhanced support to a larger number of discharges – in the last year, the borough has seen a two-fold increase in the number of discharges, many of which have also shown a rise in complexity.
5. Hospital-based social workers are part of the hospital discharge MDT meetings. There are also twice weekly morning calls attended by staff from the LIFE D2A team, recently extended to daily, where operational issues are discussed, and plans agreed. As per the national discharge guidance action cards, acute colleagues complete a D2A referral form (Part A) providing information on the type of support needed for discharge, as well as a limited functional assessment. This information is used to provide the resident with an interim care package to support safe discharge and settle the resident home. This is followed by a Part B assessment in the resident's place of residence; the Part B assessor assesses and co-ordinates the

recovery care package, liaising with therapy/reablement and other care providers, as appropriate.
A review of the LIFE service has found that Part A and Part B processes and communication between acute and community teams involved in discharge could be further improved to deliver a rehab/reablement focused approach. Proposed changes are currently being trialled to involve closer working with reablement providers.

6. The proposed changes will be complemented by opportunities to strengthen existing joint working arrangement with the hospital integrated discharge team
7. The LIFE Service will also work to develop a stronger relationship with the locality ICN+ teams to ensure residents who need low level support, e.g. exercise, be-briending, etc, can access using existing community assets, to maintain their health and well-being and prevent readmission.

The local hospital discharge team has also been reviewed and redesigned to ensure more timely and effective discharges from the wards. The new team will be implemented in Q3 and Q4 of 2021/22, depending on successful recruitment and embedding of changed processes and ways of working. As such, we are not expecting the impact of the new team to be fully embedded until the end of Q4.

Approach to improving outcomes for people discharged from hospital

We have introduced Community-led support across discharge teams. Staff have received training on the 'good conversation' tool. The training will enable them to offer community support and non-funded solutions at the point of options being discussed with patients and families. The Community Connect map will be used as a first point of contact and on triage to inform available alternative options at every conversation with the person. Key features of this approach are:

- No decision about a patient's long term care needs should be taken in an acute setting
- Follow up assessment and care should be timely and pro-active in the post-acute recovery phase with links to on-going community support
- Improved patient outcomes and experience at each part of the acute urgent care pathway and timely options for discharge with the appropriate assessment for "home" in the appropriate setting
- Care at home wherever possible with a view to enabling people to remain safe and independent in their own homes for as long as possible
- Review the emergency readmissions data over 50s to identify support within the integrated locality teams (ICN+) that could prevent readmissions
- Review the number of placements in the last 6 months to see if they could have gone home they had received night sitting

Over the next few months of winter some additional resources will be put in place to support safe, timely and effective discharge; improve the quality of discharges and avoid re-admission to hospital.

- Supporting ward staff. Providing dedicated staff from the LA in supporting D2A from wards with home first principal and focusing on Pathway 0 where possible with support from partner agencies. Providing 3 staff per day working directly with ward teams.
- Increasing voluntary sector support to help discharge and prevent re-admission. Increase offer of voluntary sector such as Age UK and Red Cross in providing

enhanced support for people when they return home to help them for 2 weeks to regain independence and prevent re-admissions.

- Using assistive technology and staff to prevent hospital admission. Using assistive technology to support this and provide crisis support for short term period.
- Emergency home care packages of care to prevent admission. 7 days funding for emergency cases to prevent hospital admission whilst long term support/care is provided. This may include waking night support if required.
- Using ICN+ to check on most vulnerable residents to prevent admission. ICN+ winter check on clients over 85 on what they have in place for winter. Ensuring everyone who is being discharged is discussed at a multi-agency GP huddle and reviewed by the ICN+ team.
- Supporting staff training to maximise independence of residents and prevent hospital admission. Training for the current staff on developing assessments and person-centred goal setting. Also supporting and enabling positive risk- taking to maximise independence.
- Educating and support residents. Campaign on educating more people on staying well and warm. Getting neighbours to look after each other.

5.0 Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Disabled Facilities Grant provides the source of funding for adaptations for owner occupiers, private and housing association tenants to facilitate major adaptations to their homes. Adaptations include provision of ramps, door widening for wheelchair access, level access showers, hoists, through-floor lifts, stair-lifts etc. Target group is clients with a disability of all ages, borough-wide, including paediatric clients/children. Assessments of need are carried out via Health OT's in adults and Children's services.

The Ministry for Housing, Communities and Local Government allocation for 2021-22 is £2,992,679.00.

The DFG is a mandatory grant which is subject to a means test. The criteria for this grant are set out in statute. Based on the current average spend of £11,000 per adaptation, the original budget could potentially fund 272 adaptations.

Key outcomes are:

- Provide access to suitable adaptations to help people to live as independently as possible in their own homes for longer.
- Allows people to self-manage long term condition(s) rather than rely on other forms of long-term support i.e. personal care using a level access shower rather than washed by care-workers.
- Prevent the need for costly residential placements, by provision of adaptations to help people use essential facilities within their home, move around the home and get into and out of the home.
- Improving safety of the home environment and prevents some unnecessary admissions to hospital or other clinical care settings because of lack of access to facilities in the home.
- People can stay living in their local communities for longer near to their support networks.

Performance of the DFG feeds into BCF Governance Arrangements, the Joint Commissioning Executive and also imports into Croydon's Health and Wellbeing Board.

The DFG covers children with physical, mental and OR cognitive disabilities, which come via Health's Children's OT Service.

For the provision of Assistive Technology, it is the OT's responsibility to assess the need of the client and they will make the referral to the Assistive Technology Team to provide the necessary equipment.

Croydon has recently updated its Private Sector Housing Assistance Policy, and now includes a range of discretionary measures under the DFG's to enable a more flexible approach to providing adaptations.

We have a fast-track grant, known as a 'Simple Adaptations Grant' for work up to £5k, whereby there is no means test and can provide such things as minor adaptations i.e. Ceiling Track Hoists, Stairlifts, Ramps. This can be turned around quickly to provide urgent adaptations as an early intervention, or to reduce the risk of hospital readmission.

We now have a Discretionary DFG, which can be given in addition to the mandatory DFG, totalling £60k. This facilitates major adaptations such as extensions to provide ground floor sleeping and washing facilities OR multiple adaptations through floor lift, Level Access Shower, Step Lift, Ceiling Track Hoists which exceed the current mandatory DFG limit of £30k.

The DFG and our enhanced reablement services are provided through the in house Staying Put Home Improvement Agency. During COVID-19 we saw an increase in referrals for our hospital discharge service. We maintained our service throughout this period, to ensure hospital beds were kept free for COVID-19 patients. We provided key safes through our Handyperson Service, blitz cleans, furniture removal to allow micro living, tackled hoarding issues, etc to enable independence and avoid hospital readmission.

The main aim of our service is to enable people to remain living safely in their own homes, and to increase their independence.

6.0 Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include:

- *Changes from previous BCF plan.*
- *How these inequalities are being addressed through the BCF plan and services funded through this.*
- *Inequality of outcomes related to the BCF national metrics.*

Croydon continues to face similar challenges as in previous years around health inequalities. The difference in how these challenges are addressed is in the shift towards more locality working via the ICN+ programme and more targeted Population health management approach. PCNs are also addressing many issues around health inequalities using population health manages and as part of the delivery of the PCN DES.

One Croydon has undertaken a series of actions that aimed to embed a strategic whole system approach to PHM, including: setting up a PHM steering group; developing a proactive and preventative framework; undertaking a BI review.

At a service level a PHM approach is routinely used in the development of new models of care and specific transformation projects i.e. ICN+, Diabetes. The ICN+ Model of Care is using a range of Localities Profiles maps which include health, social care and wider determinants data in order to understand the needs and health inequalities within localities so that resources can be targeted to address these. Further work is being done to pose specific questions for analysists to work on.

Demographics

Croydon's population is growing. The borough population recorded in Census 2001 was 330,587 and in the 2011 Census it had increased to 363,378. Based on ONS midyear estimates 2019, Croydon is home to 386,710 people and this is expected to increase to just under 500,000 by 2050. Croydon Council is the second largest of all the London boroughs in terms of population. Nearly a quarter of this figure (24.5%) is made up of young people aged 17 years or under. Around one in seven (13.8%) of our residents are aged 65 years or over. Croydon has the 4th largest proportion of young people in London which has implications on the types of services required to cater for the youth in Croydon. Like other London boroughs, Croydon has a higher proportion of residents from the BAME communities (especially Asian and Black communities) compared to the national average.

Croydon faces challenges around deprivation and inequalities in regard not only to income but other factors including health, education and housing. Over the last 4 quarters the number of households that were accepted as homeless has been over 2,000 over the year.

Future Demand for Services

People are living longer, and our population is ageing with projections suggesting that the number of people aged over 85 will increase by two thirds in Croydon by 2029. This is an important trend because we know that older people generally have more health problems and are more likely to use health and care services. The number of older people living on their own in Croydon is increasing and a far greater proportions of older people living alone, aged 75 and over, are women. Social isolation and loneliness can have a detrimental effect on health and wellbeing and people living on their own can be more at risk.

Health and social care market

Croydon has a very high number of residential and nursing care homes in the borough (128). It admits a greater number of its residents to permanent residential placement than it would like to, meaning that residents are not moved onto more suitable longer-term accommodation. Despite the high number of homes in Croydon there is often still a need to find placements outside of the borough, resulting in the undesirable outcome of an individual being cared for outside of their local area. The services provided by homes within the borough have not been developed in alignment with the requirements of our clients and therefore do not always meet their needs. There is also the growing risk of provider failure, due to the rising costs of care, which the Council is committed to addressing locally.

How inequalities are being addressed

The ICN+ programme addresses health inequalities across the borough by adopting a targeted, Locality approach based on person-centred care and using strength-based approaches. Data is analysed to understand the location and nature of health inequalities across the borough. The programme has undertaken a basic population segmentation of the borough, with understanding of key groups, their needs and their resource use. This has enabled the networks to introduce targeted preventative interventions which contribute to support people to remain independent at home.

Key features of the ICN+ model are:

- Health and Wellbeing: Recognising that people's needs may not just be physical health related, but may include Mental Health, social care needs, housing issues and other wider challenges
- Supporting people to stay well: Proactive health maintenance in a community setting, to reduce urgent and unplanned hospital visits and increase peoples' experience of good health. There will also be access to social prescribing through Personal Independence Co-ordinators (PICs)
- Long-term conditions (LTCs): Identifying those at risk of developing LTCs, and focusing on helping people with LTCs to self-manage their condition and prevent acute episodes
- Multidisciplinary: A tailored team to address the specific local needs of the population, including Mental Health services and support for Social Prescribing
- Accessible: Locally-based and locally-targeted care, Health, social care and voluntary sector staff will attend the Talking Points to provide drop-in support, focusing on a range of health and wellbeing needs
- Proactive / Population Health Management: Using a Systematic Case Finding Model to identify people who may need support, rather than waiting for them to self-present in crisis

Overall Croydon has a higher prevalence of chronic and long-term illness such as diabetes and cardiovascular conditions in BAME groups which require ongoing support from primary and community services. In addition, many BAME groups experience barriers in accessing primary care services which leads to delayed treatment, increase in A&E attendances and hospital admissions, and therefore higher costs to the health and social care system.

In order to address these and other identified issues the ICN+ programme and services funded through BCF schemes have used population health data, gathered on a locality basis, is being used to tailor the model for each local network. Different localities need a different offer and therefore need different levels of resource.

Croydon struggles with significant gaps between estimated and reported prevalence gaps for Long Term Conditions including type 2 diabetes and hypertension. To address this, we are rolling out a community outreach programme with delivery of health checks and community awareness events; aligned with ICN+ model and building on joint work during Covid-19 pandemic with public health and voluntary sector organisations to engage with specific communities and develop culturally specific materials and information.

Obesity prevalence is variable between ethnic groups with some groups (e.g. Indian and Pakistani) over 5 times more likely to develop obesity. Obesity is a risk factor in a wide range of diseases (e.g. stroke, diabetes, CHD, hypertension). Exacerbation of these conditions can result in a need for emergency care.

Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate and can lead to an increased risk of stroke. There are circa 2000 estimated number of undiagnosed cases of atrial fibrillation in Croydon. To address this, we plan to roll out systematic case finding service for of atrial fibrillation through our GP practices.

Many Type 2 diabetes patients and patients with hypertension struggle to meet the nationally recommended treatment targets. To address this, we plan to:

- Roll out an innovative new group consultations programme aimed at supporting patients with diabetes and /or hypertension to self-manage their condition more effectively.
- Roll out of a self-management programme called the Expert Patient Programme.
- Work with PCNs to deliver effective population health management strategies to provide proactive care to meet the needs of people with long term conditions.
- Support general practice to deliver the weight management directed enhanced service, which encourages practices to develop a supportive environment for clinicians to engage with patients living with obesity and diabetes and/or hypertension about their weight; ensuring effective referral pathways into local weight management services.
- Work with General Practice to onboard a further 2000 Croydon residents with non-diabetic hypoglycaemia (pre-diabetes) onto the National Diabetes Prevention Programme
- Embed of new integrated model of diabetes care in Croydon aimed at reducing the number of complications related to diabetes by investing in specialist service which would move the focus to prevention, early identification and improved management of diabetes, with the specialist team working across acute, community and primary care.

Continue shift of care using virtual/remote monitoring for people with complex/multiple long-term conditions to be cared for at home rather than hospital using telehealth.

Work with ED and acute and community LTC specialist teams to develop and roll out new pathways for use of telehealth to avoid admission or facilitate earlier discharges.

Care Homes

Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. Approximately half are Older People's homes and the rest are MD/LD homes. Given the scale of the challenge for Croydon in supporting this large number of care homes, access to services for Care Home residents has historically been variable as some services were not commissioned to cater for care home residents; whilst specialist services commissioned for care homes, especially LD and Mental Health, have always been

extremely stretched. To address this inequity of access we are putting more investment into ICN+ so that residents in every care home can have the same level of access to locality services as any other Croydon resident. We are also beefing up provisions for MH/Dementia and LD residents in care homes, whilst also working with the voluntary sector to put provisions in place to reach out to these cohorts of clients.

Inequality of outcomes linked to BCF metrics

BCF metrics are routinely monitored via our one Croydon system dashboard. Additionally, we have recently established a brand-new Croydon Population Health Management Group to look at a system-wide strategy for implementing population health management and addressing health inequalities across a spectrum of areas of work. We will ensure that BCF metrics are included to monitor any inequality of outcomes for the key BCF metrics.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

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

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

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

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 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 CCG 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.

4. Scheme Type and Sub Type:

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

5. Area of Spend:

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “CCG minimum” then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:

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

8. Source of Funding:

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

9. Expenditure (£) 2021-22:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme

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

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB 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 average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

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.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service 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.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- 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) for the Residential Admissions numerator measure.
- 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 planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned 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.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 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 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist: Complete:
Health and Wellbeing Board:	Croydon	Yes
Completed by:	Paul Connolly and Daniele Serdoz	Yes
E-mail:	one.croydon.alliance@croydon.gov.uk	Yes
Contact number:	020 3923 9524	Yes

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

Job Title:	Corporate Director of Adult Social & Health (DASS)	Yes
Name:	Annette McPartland	Yes

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting	Yes
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 19/01/2022	Yes

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Janet	Campbell	janet.campbell@croydon.gov.uk	Yes
	Clinical Commissioning Group Accountable Officer (Lead)		Sarah	Blow	sarah.blow@swlondon.nhs.uk	Yes
	Additional Clinical Commissioning Group(s) Accountable Officers	Croydon Place based Leader	Matthew	Kershaw	matthew.kershaw1@swlondon.nhs.uk	Yes
	Local Authority Chief Executive		Katherine	Kerswell	katherine.kerswell@croydon.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Annette	McPartland	annette.mcpartland@croydon.gov.uk	Yes
	Better Care Fund Lead Official		Daniele	Serdoz	daniele.serdoz@swlondon.nhs.uk	Yes
	LA Section 151 Officer		Richard	Ennis	richard.ennis@croydon.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence -->						Yes
						Yes
						Yes

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Croydon

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,992,679	£2,992,679	£0
Minimum CCG Contribution	£27,768,137	£27,768,137	£0
iBCF	£9,684,754	£9,684,754	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£1,292,000	£1,292,000	£0
Total	**£41,737,570**	**£41,737,570**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£7,890,917
Planned spend	£15,913,906

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£10,613,056
Planned spend	£10,657,000

Scheme Types

Assistive Technologies and Equipment	£446,000	(1.1%)
Care Act Implementation Related Duties	£658,000	(1.6%)
Carers Services	£279,936	(0.7%)
Community Based Schemes	£13,959,910	(33.4%)
DFG Related Schemes	£2,992,679	(7.2%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of (	£0	(0.0%)
Home Care or Domiciliary Care	£3,644,000	(8.7%)
Housing Related Schemes	£133,000	(0.3%)
Integrated Care Planning and Navigation	£2,920,628	(7.0%)
Bed based intermediate Care Services	£2,500,696	(6.0%)
Reablement in a persons own home	£3,807,000	(9.1%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£8,990,123	(21.5%)
Prevention / Early Intervention	£85,000	(0.2%)
Residential Placements	£1,320,599	(3.2%)
Other	£0	(0.0%)

Total	**£41,737,571**

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	189.0	225.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	12.9%	13.4%
	LOS 21+	6.8%	7.4%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	93.4%

Residential Admissions

		20-21 Actual	21-22 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	598	484

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.7%

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: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Croydon

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Croydon	£2,992,679
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,992,679**

iBCF Contribution	Contribution
Croydon	£9,684,754
Total iBCF Contribution	**£9,684,754**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

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

Checklist

Complete:

Yes

Yes

CCG Minimum Contribution	Contribution
NHS Croydon CCG	£27,768,137
Total Minimum CCG Contribution	**£27,768,137**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Croydon CCG	£1,144,000	LIFE Additional Contribution
NHS Croydon CCG	£148,000	Local Voluntary Partnership
Total Additional CCG Contribution	**£1,292,000**	
Total CCG Contribution	**£29,060,137**	

	2021-22
Total BCF Pooled Budget	**£41,737,570**

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

Yes

Yes

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

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Croydon

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,992,679	£2,992,679	£0
Minimum CCG Contribution	£27,768,137	£27,768,137	£0
iBCF	£9,684,754	£9,684,754	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£1,292,000	£1,292,000	£0
Total	**£41,737,570**	**£41,737,570**	**£0**

Required Spend

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

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£7,890,917	£15,913,906	£0
Adult Social Care services spend from the minimum CCG allocations	£10,613,056	£10,657,000	£0

Checklist

Column complete:

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

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Edgecome Unit	Provision of rapid integrated care access to specialist clinical	Bed based intermediate Care Services	Rapid/Crisis Response		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£1,197,231	Existing
2	Urgent Care / Roving GP (part of CUCA)	Roving GP for patients at risk of being admitted to hospital without primary	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£489,676	Existing
3	Croydon Community SLA - TACS (BCF)	Community based services supporting out of hospital care	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,790,589	Existing
4	Croydon Community SLA - TACS Nusing	This service is an expansion of the Rapid Response unit with 3	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£231,509	Existing
5	Croydon Community SLA - ICN / LIFE	This service ensure sthat vulnerable/at risk patients are better	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£410,730	Existing
6	Croydon Community SLA - COPD (BCF)	Delivery of a whole system redesign of the COPD service including:	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£591,255	Existing

7	Croydon Community SLA - Falls (BCF)	The provision of an integrated falls service largely focusing on older	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£249,666	Existing
8	Croydon Community SLA - Enhanced Care	Expansion of case management capacity (additional Health Visitor	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£178,171	Existing
9	Diabetes Service (BCF)	The service aims to improve the outcomes for people with diabetes	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,120,025	Existing
10	Intermediate Care Beds (BCF)	Intermediate Care beds in nursing homes with community geriatrician	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£726,465	Existing
11	St Christopher's Hospice - Palliative Care (BCF)	Provision of specialist palliative care from St Christopher's hospice,	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£1,969,254	Existing
12	EOL Respite	Provision of a respite service for carers of peeople on an EoL	Carers Services	Respite services		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£86,210	Existing
13	End of Life Care GSF (ST CHRISTOPHER'S	Supporting the delivery of advanced care planning for end of life	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£202,950	Existing
14	Marie Curie (BCF)	Marie Curie service supporting people to die at home	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£144,687	Existing
15	End of Life Care Training (BCF)	Provision of community engagement initiatives such as promotion of	Carers Services	Other	Supporting people to stay at home in the last	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£25,626	Existing
16	Integrated Stroke Service (BCF)	Support stroke patients to achieve mutually agreed, realistic	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£65,674	Existing
17	Age Uk -Integrated Falls Service (BCF)	Age UK Croydon Personal Safety (Falls Prevention) Service	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£61,716	Existing
18	Age UK - PICs - OOH	Implementation of Personnel Independence Coordinators service	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£906,540	Existing
19	Medicines Management - OOH BCF	Domiciliary medicines review service preventing a hospital	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum CCG Contribution	£124,637	Existing
20	Medicines Optimisation - Community (BCF)	Scheme currently on hold	Community Based Schemes	Other	Scheme currently on hold	Community Health		CCG			CCG	Minimum CCG Contribution	£0	Existing
21	Diabetes Locally Commissioned Services	A community service, reducing the number of patients being managed	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum CCG Contribution	£161,840	Existing
22	Basket Locally Commissioned Services	Delivery within Primary Care additional services (such as complex leg	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum CCG Contribution	£471,541	Existing
23	PDDS excluding Prescribing Scheme (BCF)	Practice Development and Delivery local scheme to engage	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			CCG	Minimum CCG Contribution	£2,146,824	Existing
24	SLaM BCF Community Funding (BCF)	Home Treatment teams support secondary mental health services.	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,682,292	Existing

25	SLaM MHOA BCF Funding (BCF)	This service helps to keep people out of hospital as it provides	Personalised Care at Home	Mental health /wellbeing		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£330,943	Existing
26	MHOA Dementia - Altzheimers (BCF)	Development of communication material e.g leaflet to support	Carers Services	Other	Dementia service to support carers	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£168,100	Existing
27	Care UK - Amberley Lodge (BCF)	Provision of community in-patient care for patients with mental	Residential Placements	Other	Mental health support	Community Health		CCG			Private Sector	Minimum CCG Contribution	£4,599	Existing
28	Step Down & Convalescence Beds	Procurement of step down beds for hospital discharge	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum CCG Contribution	£577,000	Existing
29	TACS - Social Work Input	Social workers assigned to GP clusters in Croydon who attend the	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Local Authority	Minimum CCG Contribution	£498,000	Existing
30	Life Reablement - OOH	An integrated community based single team under one	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Private Sector	Minimum CCG Contribution	£983,000	Existing
31	Mental Health - Reablement	MH reablement service offering interventions that aim to restore life	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£205,000	Existing
32	Mental Health - Packages of Care	Packages of care for adult MH due to increased LOS	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	Minimum CCG Contribution	£347,000	Existing
33	A&E Triage	Service to facilitate discharge from A&E (instead of admission to	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£181,000	Existing
34	Hospital Discharge	The team carry out assessments and arrange packages of care for	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£181,000	Existing
35	IAPT - Long Term Conditions Pilot	The service is at primary care level, available to anyone with a Common	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£176,000	Existing
36	Early Intervention & Reablement	This covers care for the first 6 weeks on discharge from hospital,	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	Minimum CCG Contribution	£1,172,000	Existing
37	Prevent return to acute / care home	Ongoing packages of care allowing service users to remain in their	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£549,000	Existing
38	Extended Staying Put	This service covers household tasks which are not adaptation, for	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£133,000	Existing
39	Care Support Team nurses	Service to strengthen the support/preventative	Prevention / Early Intervention	Other	Care homes support	Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£85,000	Existing
40	Alcohol Diversion	The post co-ordinates multi agency care plans for a specific cohort who	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£66,000	Existing
41	Spealist Equipment eg Telehealth /	This scheme covers aspects of staff, licenses and equipment relating	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£205,000	Existing
42	Shared Lives - Assisted Housing (MH OBD LoS)	Expansion of the Shared Lives service delivered by Croydon Council. This	Residential Placements	Supported living		Social Care		LA			Local Authority	Minimum CCG Contribution	£43,000	New

43	Demographic pressures - package of care	This is a contribution to overall funding to packages of care,	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£2,386,000	Existing
44	Care Act	Implementation of new statutory duties to the Council arising from the	Care Act Implementation Related Duties	Other	Combination of duties	Social Care		LA			Local Authority	Minimum CCG Contribution	£658,000	Existing
45	Social Care Pressures	A contribution to the overall funding of packages of care,	Residential Placements	Care home		Social Care		LA			Private Sector	Minimum CCG Contribution	£1,273,000	Existing
46	Social Care (Careline)	Careline alarm is designed to help older, frail or disabled people	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£241,000	Existing
47	Drug & Alcohol - Out of Hospital Business Case	Integrated substance misuse service to reable people in the community	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£190,000	Existing
48	iBCF	2 LA schemes funded through iBCF focuse on: Scheme 1: Supporting	Community Based Schemes	Other	iBCF schemes	Social Care		LA			Local Authority	iBCF	£9,684,754	Existing
49	BCF Baseline LIFE	Additional contribution to the LIFE service for increased packages of	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Private Sector	Minimum CCG Contribution	£508,000	Existing
50	DFG	DFG schemes. (please refer to narrative)	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Private Sector	DFG	£2,992,679	Existing
51	BCF Annual Growth	Additional Schemes to support admissions avoidance for frailty	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£572,389	New
52	LIFE Additional	Additional contribution to the LIFE service	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Additional CCG Contribution	£1,144,000	Existing
53	Local Voluntary Partnership	Local Voluntary Partnership	Community Based Schemes	Integrated neighbourhood services		Community Health		LA			Charity / Voluntary Sector	Additional CCG Contribution	£148,000	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Croydon

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative		Checklist: Complete:
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	189.0	225.0	Using 19-20 (253 avoidable admissions) we have set a target of 10% reduction in avoidable admissions for 21-22. This is beause COVID 19 has impacted on the number of avoidable admissions in 20-21 and partially 21-22. Therefore we have used 19-20 as the baseline. There are also a number of unknowns that we expect to impact on	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**	Yes

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments		
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	12.9%	13.4%	The plan for quarter 3 and 4 21/22 aligns with the forcastered figures which have been based on current performance. This is because we are anticipating a challenging winter whereby maintaining the current status quo would be considered a success. To help achieve these targets the local systems discharge team has also been reviewed and redesigned to ensure more timely and effective discharges from the wards.	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**	Yes
	Proportion of inpatients resident for 21 days or more	6.8%	7.4%			Yes

8.3 Discharge to normal place of residence

	21-22 Plan	Comments		
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)	93.4%	Croydon place has implemented a number of programmes in the last two years that has supported people to be discharged from hospital to their normal place of residence. These include Discharge to Assess, LIFE service, ICN+, Staying Put (housing and adaptations). These programmes have contributed to a percentage of	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**	Yes

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
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	436	380	598	484	Partners are following a home first policy for admissions into residential homes. Demand is projected to be less than 20/21 from the covid-19 pandemic. Any referrals will be looked at in line with this policy and based on demand that is predicted for 21/22. We are also looking at where referrals can go into Extra
	Numerator	233	202	323	270	
	Denominator	53,391	53,197	54,048	55,731	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Yes

Yes

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (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

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	93.3%	86.6%	87.7%	(Note 19/20 denominator figure is 1682 and the numerator was 1473, 322/372 is quarterly report we are unsure why these were submitted)
	Numerator	347	322	1,682	
	Denominator	372	372	1,918	LIFE team to work closely with hospital integrated discharge team and localities/ICN+ to achieve the

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Yes

Yes

Yes

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Croydon

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Checklist Complete:
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes				Yes
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes				Yes
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	The Croydon Private Sector Housing Assistance Policy 2021, sets out the detail of how Croydon manages the DFG Capital Programme and its delivery. See pages 25,32 & 40			Yes
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes

NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes				Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes				Yes
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes				Yes

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