BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.
5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

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

5. Income

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

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

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

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

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

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

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

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

6. Expenditure

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

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

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

On this sheet please enter the following information:

1. Scheme ID:

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

2. Scheme Name:

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

3. Brief Description of Scheme

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

4. Scheme Type and Sub Type:

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

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

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

6. Area of Spend:

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

7. Commissioner:

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

8. Provider:

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

9. Source of Funding:

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

10. Expenditure (£) 2023-24 & 2024-25:

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

11. New/Existing Scheme

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

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

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

7. Metrics

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

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

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

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

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

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

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

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

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

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

Health and Wellbeing Board:	Croydon
Completed by:	Daniele Serdoz
E-mail:	daniele.serdoz@swlondon.nhs.uk
Contact number:	020 3923 9524
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No
If no please indicate when the HWB is expected to sign off the plan:	Wed 28/06/2023

<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Yvette	Hopley	yvette.hopley@croydon.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Matthew	Kershaw	matthew.kershaw1@nhs.net
	Additional ICB(s) contacts if relevant	Mr	Mike	Sexton	mike.sexton@nhs.net
	Local Authority Chief Executive	Ms	Katherine	Kerswell	Katherine.Kerswell@croydon.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Ms	Annette	McPartland	Annette.McPartland@croydon.gov.uk
	Better Care Fund Lead Official	Mr	Daniele	Serdoz	Daniele.Serdoz@swlondon.nhs.uk
	LA Section 151 Officer	Ms	Jane	West	Jane.West@croydon.gov.uk
Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Croydon

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,992,679	£2,992,679	£2,992,679	£2,992,679	£0
Minimum NHS Contribution	£31,000,447	£32,755,072	£31,000,447	£32,755,072	£0
iBCF	£9,978,112	£9,978,112	£9,978,112	£9,978,112	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,398,916	£2,322,200	£1,398,916	£2,322,200	£0
ICB Discharge Funding	£1,519,000	£2,729,000	£1,519,000	£2,729,000	£0
Total	**£46,889,154**	**£50,777,063**	**£46,889,154**	**£50,777,063**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,809,448	£9,308,063
Planned spend	£17,088,418	£18,125,952

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£11,848,453	£12,519,076
Planned spend	£12,278,209	£12,965,891

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	154.0	132.0	165.0	150.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,844.0	1,607.0
	Count	985	864
	Population	53416	53416

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.5%	93.6%	93.3%	93.1%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	89	540

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	96.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

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

3.1 Demand - Hospital Discharge

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

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

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

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

Estimated levels of discharge should draw on:

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

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

3.2 Demand - Community

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

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

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

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

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

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

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

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

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

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

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

3.4 Capacity - Community

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

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

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

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

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

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

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

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

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

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

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	More information in the narrative document. Margin of Error Following a review of the data from this and previous years we believe there is a variance or margin of error on predicted demand of between 7 – 10%. This number is higher than what we would have like to see but we are in the process of introducing new systems and measures that will allow us to refine our predictive model that will improve future forecasts. ALso many assumptions have not been able to

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

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

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s......)	Social support (including VCS) (pathway 0)												
CROYDON HEALTH SERVICES NHS TRUST		46	42	48	40	53	44	42	51	42	50	45	41
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST													
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s......)	Reablement at home (pathway 1)												
CROYDON HEALTH SERVICES NHS TRUST		170	203	173	191	161	184	352	352	352	352	352	352
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST		10	13	11	12	10	11	22	22	22	22	22	22
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		21	25	21	24	20	23	44	44	44	44	44	44
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST													
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		27	32	27	30	25	29	55	55	55	55	55	55
OTHER		37	45	38	42	35	40	77	77	77	77	77	77
(Please select Trust/s......)	Rehabilitation at home (pathway 1)												
CROYDON HEALTH SERVICES NHS TRUST		18	22	21	20	21	18	24	25	25	29	25	38
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST		1	1	1	1	1	1	1	2	2	2	2	2
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		2	3	3	2	3	2	3	3	3	4	3	5
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST													
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		3	3	3	3	3	3	4	4	4	5	4	6
OTHER		4	5	5	4	5	4	5	5	5	6	6	8
(Please select Trust/s......)	Short term domiciliary care (pathway 1)												
CROYDON HEALTH SERVICES NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST													
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s......)	Reablement in a bedded setting (pathway 2)												
CROYDON HEALTH SERVICES NHS TRUST		0	0	0	0	0	0	0	0	0	1	1	1
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST		104	104	104	104	104	104	104	104	104	104	104	104
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s......)	Rehabilitation in a bedded setting (pathway 2)												
CROYDON HEALTH SERVICES NHS TRUST		19	20	19	20	20	19	20	19	20	20	19	20
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST		1	1	1	1	1	1	1	1	1	1	1	1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST													

Trust	Service	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
OTHER		2	2	2	2	2	2	2	2	2	2	2	2
(Please select Trust/s......)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
CROYDON HEALTH SERVICES NHS TRUST		0	0	0	0	0	0	0	0	0	8	8	8
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST													
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
Totals	**Total:**	467	523	479	498	466	487	758	768	760	785	773	789

3.2 Demand - Community

Demand - Intermediate Care												
Service Type	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Social support (including VCS)	77	77	77	77	77	77	77	77	77	77	77	77
Urgent Community Response	374	293	334	356	341	310	431	362	468	374	381	406
Reablement at home	89	89	89	89	89	89	130	130	130	130	130	130
Rehabilitation at home	5	5	5	5	5	5	5	5	5	5	4	5
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	4	4	4	4	4	4	4	4	4	4	4	4
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**ICB**	**LA**	**Joint**
Social support (including VCS)	Monthly capacity. Number of new clients.	50	50	50	50	50	50	50	50	50	50	50	50	100%		
Reablement at Home	Monthly capacity. Number of new clients.	312	312	312	312	312	312	550	550	550	550	550	550			100%
Rehabilitation at home	Monthly capacity. Number of new clients.	14	15	14	15	15	14	37	39	39	46	40	59			100%
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Reablement in a bedded setting	Monthly capacity. Number of new clients.	104	104	104	104	104	104	104	104	104	106	106	106		100%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	18	19	18	19	19	18	19	18	19	19	17	19	100%		
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	14	13	14			100%

3.4 Capacity - Community

Capacity - Community														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**ICB**	**LA**	**Joint**
Social support (including VCS)	Monthly capacity. Number of new clients.	81	81	81	81	81	81	81	81	81	81	81	81	100%		
Urgent Community Response	Monthly capacity. Number of new clients.	374	293	334	356	341	310	431	362	468	374	381	406	100%		
Reablement at Home	Monthly capacity. Number of new clients.	87	87	87	87	87	87	130	130	130	130	130	130			100%
Rehabilitation at home	Monthly capacity. Number of new clients.	3	3	3	3	3	3	5	5	5	5	4	5			100%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Other short-term social care	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2		100%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Croydon

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Croydon	£2,992,679	£2,992,679
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,992,679**	**£2,992,679**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Croydon	£1,398,916	£2,322,200

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS South West London ICB	£1,519,000	£2,729,000
Total ICB Discharge Fund Contribution	£1,519,000	£2,729,000

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Croydon	£9,978,112	£9,978,112

Total iBCF Contribution	**£9,978,112**	**£9,978,112**

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

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

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS South West London ICB	£31,000,447	£32,755,072
Total NHS Minimum Contribution	**£31,000,447**	**£32,755,072**

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

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£31,000,447**	**£32,755,072**	

	2023-24	2024-25
Total BCF Pooled Budget	**£46,889,154**	**£50,777,063**

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Croydon

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,992,679	£2,992,679	£0	£2,992,679	£2,992,679	£0
Minimum NHS Contribution	£31,000,447	£31,000,447	£0	£32,755,072	£32,755,072	£0
iBCF	£9,978,112	£9,978,112	£0	£9,978,112	£9,978,112	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,398,916	£1,398,916	£0	£2,322,200	£2,322,200	£0
ICB Discharge Funding	£1,519,000	£1,519,000		£2,729,000	£2,729,000	£0
Total	**£46,889,154**	**£46,889,154**	**£0**	**£50,777,063**	**£50,777,063**	**£0**

Required Spend

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

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,809,448	£17,088,418	£0	£9,308,063	£18,125,952	£0
Adult Social Care services spend from the minimum ICB allocations	£11,848,453	£12,278,209	£0	£12,519,076	£12,965,891	£0

Checklist

Column complete:

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

>> Incomplete fields on row number(s):

60, 61,
62, 63,
64, 65,
66, 67,
68, 69,
70, 71,
72, 73,
74, 75,
76, 77,
78, 79,
80, 81,
82, 83,
84, 85,
86, 87,
88, 89,
90, 91,
92, 93,
94, 95,
96, 97,
98, 99,
100, 101,
102, 103,
104, 105,
106, 107,
108, 109,
110, 111,
112, 113,
114, 115,
116, 117,
118, 119,
120, 121,

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Integrated SDEC	Provision of rapid integrated care access to specialised treament within Croydon University Hospital to stop the need for a hospital	Integrated care planning and navigation	Assessment teams/joint assessment					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution
2	Rapid Response GP Cover	Roving GP for patients at risk of being admitted to hospital without primary care intervention. Immediate access to a GP medical opinion will	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution

3	Integrated Community Network Plus (ICN+) - (Croydon Community SLA)	Locality based multi disciplinary teams organised around neighbourhoods and GP practices to deliver proactive and personalised care, ensuring that vulnerable/at risk patients are better supported out of hospital therefore benefitting from integrated delivery of care from health, social care, mental health and voluntary sector services.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
4	LIFE service - (Croydon Community SLA)	Living Independently for Everyone (LIFE) is a an integrated intermediate care service that focuses on delivering the Croydon Discharge to Assess (D2A) model of care, supporting people discharged from hospital to recover, reable and rehabilitate in their own home. Some Step up users are also cared for.	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		113465	115507	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
5	Intermediate Care Beds (Pathway 2 Rehab)	Intermediate Care beds for rehabilitation in nursing homes with community geriatrician input and the LIFE wrap-around service. Step up	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		261	442	Number of Placements	Community Health		NHS			Private Sector	Minimum NHS Contribution
6	Community COPD (Croydon Community SLA)	Integrated COPD service including: increase the number of spirometry measurements; adopt evidence based clinical pathways; increase	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
7	Integrated Falls Service (Croydon Community SLA)	The provision of an integrated falls service largely focusing on older people who have experienced a fall and present either at CHS	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
8	Personal Safety - Falls prevention service service	Age UK Croydon Personal Safety (Falls Prevention) Service (Handyman service); to remove trip hazards from service users' home.	Prevention / Early Intervention	Risk Stratification					Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
9	Integrated Diabetes Service	The service aims to improve the outcomes for people with diabetes through delivering structured education to help them better	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
10	Personal Independence Coordinators	Personnel Independence Coordinators support people to remain independent at home for as long as possible, through proactive and	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
11	Specialist Palliative Care Services	Provision of specialist palliative care from St Christopher's hospice, incorporating inpatients/outpatients (Community, care home	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
12	EOL Care Respite Service	Provision of a respite service for carers of people on an EoL pathway. Currently provided by a Home care agency but looking to reprocure.	Carers Services	Respite services		22	22	Beneficiaries	Social Care		NHS			Private Sector	Minimum NHS Contribution
13	End of Life Community Engagement	Supporting the delivery of advanced care planning for end of life care patients through training and development of local workforce;	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
14	EoL Night Sitting Service	Service supporting people to die at home with the provision of night nursing and sitting. Currently Provided by Marie Curie.	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
15	EOL Advanced Care Planning Facilitator	Advanced Care Plan Facilitator within the palliative care team, to ensure streamlined and consistent support in acute and community	Personalised Care at Home	Other	End of Life care planning				Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
16	EOL Choose Home	Rapid response service to support people who are imminently dying to remain at home with the provision of a wrap-around service or to be	Personalised Care at Home	Other	Endof Life support				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
17	Red Bag Discharge Coordinator	A discharge coordinator focusing on the Red Bag scheme - to ensure discharges into care homes are not delayed and care homes are empowered	High Impact Change Model for Managing Transfer of Care	Red Bag scheme					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
18	Medicines Management - ICN+ pharmacists	Pharmacists as part of the Integrated Community Network plus programme tosupport domiciliary medicines review preventing a	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Primary Care		NHS			NHS Acute Provider	Minimum NHS Contribution
19	Diabetes Locally Commissioned Services	A community service, reducing the number of patients being managed in the acute setting. Housebound patients are seen by the service.	Personalised Care at Home	Physical health/wellbeing					Primary Care		NHS			NHS	Minimum NHS Contribution
20	Basket Locally Commissioned Services	Delivery within Primary Care additional services (such as complex leg ulcer dressing, shared care pathways with the acute hospital) that ensure	Personalised Care at Home	Physical health/wellbeing					Primary Care		NHS			NHS	Minimum NHS Contribution
21	Proactice Care Locally Commissioned	Locally commissioned service with General Practice to implement proactive and personalised care - through developing	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Primary Care		NHS			NHS	Minimum NHS Contribution
22	Adult MH Home treatment team	Home Treatment teams are a secondary mental health team who are part of the Trusts crisis provision. They support mental health service	Personalised Care at Home	Mental health /wellbeing					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
23	OA MH Home Treatment team	The Older Adult Home Treatment is a multi-disciplinary service which supports patients who are experiencing a mental health crisis. The	Personalised Care at Home	Mental health /wellbeing					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution

24	MHOA Dementia - Altzheimers (BCF)	Development of communication material e.g leaflet to support access to services that support implementation of the integrated service	Integrated Care Planning and Navigation	Care navigation and planning					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
25	Frailty Practioners (ICN+)	Roles in ED and the community to implement the croyodn integrated frailty model, to support early identification of frailty or those at risk of	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
26	Neighbourhood development programme	Programme of work to improve BCF funded localities and development including LTC management and respiratory hubs	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS	Minimum NHS Contribution
27	TACS - Social Work Input	Social workers assigned to GP clusters in Croydon who attend the weekly huddles where early intervention can make a difference	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
28	Life Reablement - OOH	An integrated community based single team under one management structure, using an agreed single eligibility assessment and review	Reablement in a persons own home						Social Care		LA			Private Sector	Minimum NHS Contribution
29	Mental Health Reablement	MH reablement service offering interventions that aim to restore life skills and build resilience in meeting non-medical issues such as	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			NHS Mental Health Provider	Minimum NHS Contribution
30	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 (Discharge to Assess pathway 1)		18148	18148	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
31	A&E Triage	Service to facilitate discharge from A&E (instead of admission to hospital) by arranging short term packages of care, sign-posting to other	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		9466	9466	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
32	Hospital DIscharge	The team carry out assessments and arrange packages of care for people who are ready to be discharged from hospital.	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		9466	9466	Hours of care	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
33	IAPT Long Term conditions pilot	The service is at primary care level, available to anyone with a Common Mental Illness (CMI). The Service supports people to recovery and	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			NHS Mental Health Provider	Minimum NHS Contribution
34	Early Intervention and reablement	This covers care for the first 6 weeks on discharge from hospital, with the intention of reabling rather than continuing as a long term	Reablement in a persons own home						Social Care		LA			Private Sector	Minimum NHS Contribution
35	Prevent return to acute/ Care Home	ongoing packages allowing service users to remain in their own homes	Home Care or Domiciliary Care	Domiciliary care packages		28713	28713	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
36	Extended Staying Put	This service covers household tasks which are not adaptation, for example, blitz clean, help with boarding issues, help with moving home	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution
37	Care Support Team Nurses	Service to strengthen the support/preventative measures provided to care and nursing residential homes and nursing homes to support	Prevention / Early Intervention	Other	care homes support				Social Care		LA			NHS Community Provider	Minimum NHS Contribution
38	Alcohol Diversion	The post co-ordinates multi agency care plans for a specific cohort who have a long term health condition that is made worse by	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
39	Specialist Equipment eg Telehealth /	This scheme covers aspects of staff, licenses and equipment relating to telehealth/care	Assistive Technologies and Equipment	Assistive technologies including telecare		489	489	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
40	Shared Lives - Assisted Housing (MH OBD LoS)	Expansion of the Shared Lives service delivered by Croydon Council. This service provides short term placements for people with MH support	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
41	Demographic pressures - package of care	This is a contribution to overall funding to packages of care, recognizing demographic pressures which lead to increased demand for	Home Care or Domiciliary Care	Domiciliary care packages		124790	124790	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
42	Care Act	Implementation of statutory duties to the Council arising from the Care Act	Care Act Implementation Related Duties	Other	Support on advocacy and carers				Social Care		LA			Local Authority	Minimum NHS Contribution
43	Social care pressures	A contribution to the overall funding of packages of care, recognising demographic pressures which lead to increased demand for	Residential Placements	Care home		27	27	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
44	Social Care (Careline)	Careline alarm is designed to help older, frail or disabled people to remain in their own homes to be able to summon assistance in an	Assistive Technologies and Equipment	Assistive technologies including telecare		374	374	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
45	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 NHS Contribution
46	Packages of Care	Meeting social care needs and supporting people to be discharged from hospital	Home Care or Domiciliary Care	Domiciliary care packages		74642	74642	Hours of care	Social Care		LA			Private Sector	iBCF
47	BCF Basline LIFE	Additional contribution to the LIFE service for increased packages of care since 2020/21	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		26569	26569	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution

48	DFG	DFG schemes - to provide vital adaptations to the residents property to enable and promote independance. Type of adaptations would	DFG Related Schemes	Adaptations, including statutory DFG grants		190	190	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG
49	Discharge to Assess	To continue discharge to assess	Residential Placements	Care home		41	64	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
50	LIFE Additional	Additional Contribution to the LIFE service. This contribution is not included in this plan for 2023-25.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Additional NHS Contribution
51	Step Down and Convalescence Beds	Procurement of step down beds for hospital discharge	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Private Sector	Minimum NHS Contribution
52	Home from Hospital Service	Voluntary sector support to discharge people from hospital and follow them at home soon after discharge to ensure they are safe to	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
53	Social Workers	Additional social care staffing to support hospital discharge: 1 FTE supporting Acute Care of the Elderly Ward. 0.5FTE supporting palliative	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution
54	Residential Placements	Meeting social care needs and supporting people to be discharged	Residential Placements	Care home		3065	3065	Number of beds/Placements	Social Care		LA			Private Sector	iBCF
55	Residential Placements	Meeting social care needs and supporting people to be discharged from hospital	Residential Placements	Nursing home		940	940	Number of beds/Placements	Social Care		LA			Private Sector	iBCF
56	Supported Living	Meeting social care needs	Residential Placements	Supported housing		23	23	Number of beds/Placements	Social Care		LA			Private Sector	iBCF
57	Direct Payments	The provision of LA funding to meet clients Care Act assessed care needs that provide maximum choice, flexibility & control over the services	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	iBCF
58	Social work staff	The provision of funding to support social workers based in hospitals and in the community to undertake Care Act duties to both	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	iBCF
59	Equipment for dishcarge to assess	Community Equipment supporting people to live independently in their own home and prevent ongoing risk when discharged from hospital	Assistive Technologies and Equipment	Community based equipment		10336	10336	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
60	Staffing for discharge to assess	staffing to continue discharge to assess	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution
61	discharge to assess placements	To continue discharge to assess packages and placements	Residential Placements	Supported housing		5	8	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
62	discharge to assess placements	to continue discharge to assess packages and placements	Residential Placements	Nursing home		9	14	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution
63	DIscharge to Assess placements	To continue discharge to assess, packages and placements	Home Care or Domiciliary Care	Domiciliary care packages		30492	47163	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution
64	Reablement Support Workers	A&E Liaison workers to prevent admission to hospital and facilitate discharge back to usual place of residence	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution
65	Business Support Worker	Life team support for data collection and processing / Discharge to assess pathway.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Minimum NHS Contribution
66	Interim Pathway 3 Step down beds - wrap around	Interim Staffing to support Pathway 3 Beds	Workforce recruitment and retention						Community Health		NHS			NHS Community Provider	ICB Discharge Funding
67	Increase availability for pathway 1	Increase of ischarges per week for people returing home who need care at home via pathway 1. This is above BAU arrangements as	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		31887	31887	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge
68	Interim LA Transfer of Care Staffing	5 x Staff for 6 months to support in being a key contact for pathway 1 and 3 referrals in supporting early identification of correct	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Local Authority Discharge
69	Enhanced discharge Staffing in Hospital to	1 x extra staff to be based within the hospital to include an enhanced Saturday service. This will be a full dedicated service including therapists,	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
70	Enhanced LIFE & OOB Staffing	Staff to support for 6 months the increased discharges per week we require additional staffing for LIFE and out of borough hospital	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
71	Placements & Brokerage Staffing	Staff for 6 months for 4 x Placements & Brokerage staff to support on increased home care disharges and managing the step down	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Local Authority Discharge

72	CES Equipment Costs	To support the extra discharges per week for home care there will be a need to purchase and delivery extra equipment which is above and	Assistive Technologies and Equipment	Community based equipment		125	125	Number of beneficiaries	Social Care		LA			Private Sector	Local Authority Discharge
73	Step Down Bed Staffing	3 x staff to support the pathway 3 step down beds by ensuring residents are discharged and have clear planning to step down within 28	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge
74	Locality staffing to support around ongoing care	Increased capacity within locality teams to support people discharged out of hospital to ensure ongoing care needs are met and prevent	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Local Authority Discharge
75	Transformation for hospital discharges around	Projects have been identified as part of the development of the frontrunner programme that include new/improved reablement service,	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Private Sector	Local Authority Discharge
76	Hospital Discharge Improvement programme	Implementation of the frontrunner programme (Health contrinution) that include new/improved Transfer of care hub, reablement	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
77	Interim Pathway 3 Stepdown Beds	11 step up/ step down beds	Residential Placements	Short term residential care (without rehabilitation or reablement input)		95	95	Number of beds/Placements	Community Health		NHS			Private Sector	ICB Discharge Funding
78	MH Step Down beds	Block purchase of 10 mental health step down beds	Residential Placements	Supported housing		10	10	Number of beds/Placements	Mental Health		NHS			Private Sector	ICB Discharge Funding
79	Homeless Pathway	Improved Discharge for Homeless Patients	High Impact Change Model for Managing Transfer of Care	Other	Improved Discharge of Homeless				Community Health		NHS			NHS Community Provider	ICB Discharge Funding
80	Pharmacy Discharge Team	Hospital Pharmacy Discharge Team x 3 WTE B6 to improve timely medicine provision and early discharge planning	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		NHS			NHS Acute Provider	ICB Discharge Funding
81	Winter ADU	Additional capacity in Admission and discharge unit to support winter discharges into the community	High Impact Change Model for Managing Transfer of Care	Other	Additional step down bed capacity for				Acute		NHS			NHS Acute Provider	ICB Discharge Funding
82	SWL Bed Bureau	Bed Bureau staffing in winter	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS	ICB Discharge Funding
83	Additional MH Discharge Capacity	- 1 x band 7 senior liaison clinician to support out of area discharge planning for Croydon patients placed out of care	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
84	Integrated Stroke Service (BCF)	Support stroke patients to achieve mutually agreed, realistic rehabilitative goals and maximise their recovery	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
85	Carers Support Project	Expansion of the carer's support offer to expand the range of respite services, increasing the reach of emotional support services, linking with	Carers Services	Carer advice and support related to Care Act duties		82	82	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.

8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.

18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Croydon

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	160.8	136.9	170.4	128.0	Croydon has seen an average improvement of 12% in this avoidable admission metric from 21-22 to 22-23. The actual indicator value in 22-23 was 165. As we continue to embed the work undertaken since the implementation of the localities model of care, we are expecting to sustain this performance and	To meet this ambition a number of schemes have been put in place over the last number of years that will help keep people as independent as possible at home. These include: - ICN+ teams are identifying people who are at high risk of admission and can be managed in the community, working with
	Number of Admissions	572	487	606	-		
	Population	386,710	386,710	386,710	386,710		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	154	132	165	150		

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,908.0	1,844.0	1,607.0	Local data is showing Croydon has seen an average improvement of 6% in emergency admissions due to falls from 21/22 to 22/23. And an improvement of 20% since 19/20. However we are seeing 985 falls instead of the Expected 864. As we continue to embed the work and services put in place with the implementation of the localities model of care, our ambition	Similar to above, to meet this ambition a number of schemes have been put in place over the last number of years that will help improve this ambition. These include: - ICN+ teams are identifying people who are at high risk of admission and can be managed in the community, working with an MDT and locality community assets (as described in our narrative document). This
	Count	1,030	985	864		
	Population	53,416	53416	53416		

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.3%	93.1%	93.5%	93.7%	Local data is indicating that the percentage of people discharged to their usual place of residence in Croydon has remained approximately stable in 21/22 (93.5%) and 22/23 (93.2%), with only a small deterioration. The actual performance in Q4 22-23 was 92.72% , below what we had planned. This is on the backdrop of a reduction in number of discharges. A deep dive into our discharge model has shown	Croydon place has implemented a number of programmes in the last two years that have 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 will continue to contribute to supporting people discharge back to their normal place of residence. Enhanced
	Numerator	6,613	6,516	6,708	6,848		
	Denominator	7,091	7,001	7,178	7,308		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	93.5%	93.6%	93.3%	93.1%		
	Numerator	6,940	7,108	6,945	6,351		
	Denominator	7,422	7,598	7,446	6,820		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	88.8	289.7	514.4	540.4	This is based on 22/23 estimated performance and then reduction made to take into account transformational change of Frontrunner scheme but increase factored in due to increased demands for residential beds. Pathway 3 demand has	Partners have a clear home first model in place. The Frontrunner programme and Intermediate care programme will have a clear focus on improving the pathway 3 offer with step down beds with wrap round support and the intermediate care
	Numerator	48	165	293	315		
	Denominator	54,048	56,960	56,960	58,287		

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

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.3%	93.3%	95.9%	96.0%	This is based on 22/23 estimated performance and then improvements to take into account transformational change of Frontrunner scheme of reablement offer as detailed across in the local plan to meet ambition.	The Frontrunner programme is recommending several changes around reablement to ensure earlier discharge planning and the establishment of multi-disciplinary teams for intense support for 72 hours following discharge. The
	Numerator	570	776	497	498		
	Denominator	631	832	518	519		

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

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

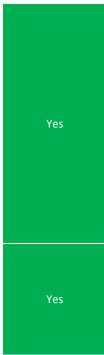
Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Croydon

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	**Complete:**
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes				Yes
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes				Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes				Yes
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes				Yes
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes				Yes

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



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