BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

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

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

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

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

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

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

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

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

4. Capacity and Demand

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

5. Income

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

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

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

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

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

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

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

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

6. Expenditure

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

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

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

On this sheet please enter the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Metrics

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

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

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

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

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

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

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

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

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

8. Planning Requirements

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

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

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

Health and Wellbeing Board:	Barnet
Completed by:	Muyi Adekoya; Gauri Mohan
E-mail:	muyi.adekoya@nhs.net ; gauri.mohan@nhs.net
Contact number:	7849629451
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Alison	Moore	cllr.a.moore@barnet.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Executive Director-	Dawn	Wakeling	dawn.wakeling@barnet.gov.uk
	Additional ICB(s) contacts if relevant	Director of Integration	Colette	Wood	colette.wood1@nhs.net
	Local Authority Chief Executive	Chief Executive	John	Hooton	john.hooton@barnet.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Director- Adults Social	James	Mass	james.mass@barnet.gov.uk
	Better Care Fund Lead Official	NCL Care Homes	Muyi	Adekoya	muyi.adekoya@nhs.net
	LA Section 151 Officer	Executive Director-	Anisa	Darr	anisa.darr@barnet.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: Barnet

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,884,527	£2,884,527	£2,884,527	£2,884,527	£0
Minimum NHS Contribution	£31,005,081	£32,759,969	£31,005,081	£32,759,969	£0
iBCF	£9,621,518	£9,621,518	£9,621,518	£9,621,518	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,348,922	£2,239,210	£1,348,922	£2,239,210	£0
ICB Discharge Funding	£2,378,500	£4,699,853	£2,378,500	£4,699,853	£0
Total	**£47,238,548**	**£52,205,077**	**£47,238,548**	**£52,205,077**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,810,765	£9,309,454
Planned spend	£20,032,830	£21,166,689

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£9,264,186	£9,788,539
Planned spend	£9,264,186	£9,788,539

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)	130.0	105.0	132.0	122.0

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	2,350.3	2,200.0
	Count	1329.13964	1300
	Population	56551	62522

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)	92.4%	92.4%	92.4%	92.4%

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	543	345

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Barnet

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, rehabilitation 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, please 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.	•R0- Barnet capacity estimate is based on previous years outturn of schemes that provide low level support. •R1- The default pathway for those leaving hospital in Barnet is reablement. Barnet's capacity and demand are similar as the council will procure the majority of placements to demand but does have some block provision. Demand for 23/24 is expected to increase slightly and has been reflected in the figures. . The combined capacity for P1 is larger than the demand as some discharges will require both health and care support; and both health and care capacity is reflected in our estimate. •R2 - Barnet has estimated a 105 of 21 days for most cases, and 42 days for more complex placements	

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!!

Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	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
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Social support (including VCS) (pathway 0)	1	1	1	1	1	1	1	1	1	1	1	1
ROYAL FREE LONDON NHS FOUNDATION TRUST		70	70	70	70	70	70	70	70	70	70	70	70
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		1	1	1	1	1	1	1	1	1	1	1	1
WHITTINGTON HEALTH NHS TRUST		1	1	1	1	1	1	1	1	1	1	1	1
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Reablement at home (pathway 1)	1	1	1	1	0	1	1	1	1	2	1	0
ROYAL FREE LONDON NHS FOUNDATION TRUST		195	224	183	166	157	167	167	186	197	216	185	158
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		21	19	17	15	17	19	25	24	24	22	23	15
WHITTINGTON HEALTH NHS TRUST		13	9	9	7	7	10	10	10	14	17	9	10
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Rehabilitation at home (pathway 1)	0	0	0	1	0	1	0	0	0	0	0	0
ROYAL FREE LONDON NHS FOUNDATION TRUST		48	35	41	114	35	99	42	23	46	8	45	79
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		6	4	4	11	4	11	7	4	6	1	7	9
WHITTINGTON HEALTH NHS TRUST		3	2	3	6	3	7	3	2	4	1	3	6
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
ROYAL FREE LONDON NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
WHITTINGTON HEALTH NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Reablement in a bedded setting (pathway 2)	0	1	0	1	0	1	1	0	0	1	0	0
ROYAL FREE LONDON NHS FOUNDATION TRUST		35	28	27	35	23	29	30	32	36	33	31	28
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		4	3	3	5	3	4	4	5	5	5	4	4
WHITTINGTON HEALTH NHS TRUST		2	1	2	1	1	1	1	2	2	2	2	1
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	0	1	0	1	0	1	1	0	0	1	0	0
ROYAL FREE LONDON NHS FOUNDATION TRUST		35	28	27	35	23	29	30	32	36	33	31	28
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		4	3	3	5	3	4	4	5	5	5	4	4
WHITTINGTON HEALTH NHS TRUST		2	1	2	1	1	1	1	2	2	2	2	1
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	0	0	0	0	0	0	0	0	0	1
ROYAL FREE LONDON NHS FOUNDATION TRUST		25	23	12	21	19	20	29	23	27	29	22	26
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST		2	1	0	1	1	0	1	1	1	1	1	1
WHITTINGTON HEALTH NHS TRUST		3	2	1	3	2	2	2	4	4	3	3	2

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	572	572	572	557	557	557	666	666	666	699	699	699
Reablement at home	53	75	127	140	146	114	127	125	84	87	57	36
Rehabilitation at home	88	88	88	88	88	88	88	88	88	88	88	88
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	29	40	30	23	17	12	15	24	37	32	17	28
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social supoort (including VCS)	Monthly capacity. Number of new clients.	81	81	81	81	81	81	81	81	81	81	81	81
Reablement at Home	Monthly capacity. Number of new clients.	255	280	233	210	201	218	225	246	260	284	243	204
Rehabilitation at home	Monthly capacity. Number of new clients.	68	49	58	158	58	142	62	35	67	13	66	111
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.	22	23	22	21	23	22	23	22	23	23	21	22
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	78	80	78	80	80	78	80	78	80	80	72	78
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	30	30	30	30	30	30	30	30	30	30	30	30

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint
100%	0%	0%
0%	100%	0%
100%	0%	0%
0%	0%	0%
100%	0%	0%
100%	0%	0%
15%	85%	0%

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	572	572	572	557	557	557	666	666	666	699	699	699
Reablement at Home	Monthly capacity. Number of new clients.	58.3	82.5	139.7	154	160.6	125.4	139.7	137.5	92.4	95.7	62.7	39.6
Rehabilitation at home	Monthly capacity. Number of new clients.	96	96	96	96	96	96	96	96	96	96	96	96
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.	29	40	30	23	17	12	15	24	37	32	17	28
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint
0%	0%	0%
100%	0%	0%
0%	100%	0%
100%	0%	0%
0%	0%	0%
100%	0%	0%
0%	0%	0%

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 (%)	98.7%

Planning Requirements >>

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

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Barnet

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Barnet	£2,884,527	£2,884,527
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,884,527**	**£2,884,527**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Barnet	£1,348,922	£2,239,210

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS North Central London ICB	£2,378,500	£4,699,853
Total ICB Discharge Fund Contribution	£2,378,500	£4,699,853

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Barnet	£9,621,518	£9,621,518
Total iBCF Contribution	**£9,621,518**	**£9,621,518**

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

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

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS North Central London ICB	£31,005,081	£32,759,969
Total NHS Minimum Contribution	**£31,005,081**	**£32,759,969**

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	**£31,005,081**	**£32,759,969**

	2023-24	2024-25
Total BCF Pooled Budget	**£47,238,548**	**£52,205,077**

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: Barnet

<< 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	£2,884,527	£2,884,527	£0	£2,884,527	£2,884,527	£0
Minimum NHS Contribution	£31,005,081	£31,005,081	£0	£32,759,969	£32,759,969	£0
iBCF	£9,621,518	£9,621,518	£0	£9,621,518	£9,621,518	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,348,922	£1,348,922	£0	£2,239,210	£2,239,210	£0
ICB Discharge Funding	£2,378,500	£2,378,500		£4,699,853	£4,699,853	£0
Total	**£47,238,548**	**£47,238,548**	**£0**	**£52,205,077**	**£52,205,077**	**£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	£8,810,765	£20,032,830	£0	£9,309,454	£21,166,689	£0
Adult Social Care services spend from the minimum ICB allocations	£9,264,186	£9,264,186	£0	£9,788,539	£9,788,539	£0

Checklist

Column complete:

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

>> Incomplete fields on row number(s):

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

									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	Seven day social care support	Support for 7 day a week discharge by ASC teams	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Social Care		LA			Local Authority	Minimum NHS Contribution

2	Seven day community health provision	Support for 7 day a week discharge by NHS provider teams	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
3	Seven day support-acute	Support for 7 day a week discharge by NHS integrated discharge teams outside of	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		NHS			Local Authority	Minimum NHS Contribution
4	Care Home Quality assurance	Quality assurance of community care home providers to enable safe	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	Minimum NHS Contribution
5	GP support to Care homes	Primary care locally commissioned services(LCS) to deliver the PCN/GP offer	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Primary Care		NHS			Private Sector	Minimum NHS Contribution
6	Monitoring Patient flow	Support for D2A pathways	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	iBCF
7	Enhanced Health in Care homes	Staff supporting the delivery of the Enhanced Health in Care Homes	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
8	Ageing Well programme	The programme aims develop community capacity to support older people to self-	Prevention / Early Intervention	Choice Policy					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
9	Self-directed support	Direct payments to support the care of people in the community settings	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	Minimum NHS Contribution
10	Memory Clinic	Support for early detection of dementia to prevent hospital admission through the	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
11	Care Packages - support at home	Building system resilience to support homefirst approach through the provision of care	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Local Authority	Minimum NHS Contribution
12	Day opportunities	Support for access to volunteering opportunities to improve wellbeing	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	iBCF
13	Community Health services	Support to regain and retain independent living skills	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution
14	Fracture liaison service	Systematic approach to secondary prevention of osteoporotic fragility	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution
15	Care Home provision	24 hour accommodation and support for those residents unable to live independently	Residential Placements	Care home		47.49	47.49	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
16	Supported Living	Accommodation with personalised support based on personalised level of	Residential Placements	Supported housing		12.21	12.21	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
17	Intermediate care /step-down	Services to support safe discharge from hospital	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
18	Winter resilience	Additional system capacity to support D2A pathways during peak periods	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		23.14	23.14	Number of Placements	Social Care		LA			Local Authority	iBCF
19	Home Care packages of support	Personalised support at home	Home Care or Domiciliary Care	Domiciliary care packages		192,995.62	192,995.62	Hours of care	Social Care		LA			Local Authority	iBCF
20	Reablement capacity	Additional system capacity to support D2A pathways during peak periods	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)		215.40	215.40	Packages	Social Care		LA			Local Authority	iBCF
21	Intermediate care /reablement	Support to regain and retain independent living skills	Home-based intermediate care services	Reablement at home (to prevent admission to hospital or residential care)		325.74	344.18	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
22	Dignity for end of life	Palliative care at home or in hospice	Personalised Care at Home	Physical health/wellbeing					Continuing Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution

23	Disabled Facilities Grant	Home adaptations & equipment	DFG Related Schemes	Adaptations, including statutory DFG grants		150.00	150.00	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG
24	Care Act Implementation	Assessment of need and safeguarding	Care Act Implementation Related Duties	Safeguarding					Other	Care Act Duties	NHS			Local Authority	Minimum NHS Contribution
25	Carers Support - Asessment & Advice	Barnet Carers centre support for unpaid carers	Carers Services	Carer advice and support related to Care Act duties		1800	1800	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
26	Carers Support	Support to unpaid carers in their caring role through provision of respite	Care Act Implementation Related Duties	Safeguarding					Social Care		NHS			Local Authority	Minimum NHS Contribution
27	Care Act duties-MH advocacy	Independent advocacy services for clients with mental ill-health	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution
28	Single point of access	Integrated approach to referral management	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
29	Admissions avoidance	Support at home to prevent health deterioration	Home-based intermediate care services	Joint reablement and rehabilitation service (to prevent admission to		321.27	339.46	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
30	Social Prescribing	Signposting to community resources to promote self-resilience	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	iBCF
31	Integrated Community Equipment	Provision of small equipment in the home to retain independent living skills	Assistive Technologies and Equipment	Community based equipment		13,869	14,654	Number of beneficiaries	Community Health		LA			Local Authority	Minimum NHS Contribution
32	Digital inclusion-Assistive Technologies	Technical support at home for self-management to prevent health deterioration	Assistive Technologies and Equipment	Digital participation services		625	625	Number of beneficiaries	Community Health		NHS			NHS	iBCF
33	Enablers to Integration	Funding to support delivery of transformation projects	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
34	Frailty MDT	Primary care funding: staff support for frailty MDT	Integrated Care Planning and Navigation	Support for implementation of anticipatory care					Community Health		NHS			Local Authority	Minimum NHS Contribution
35	Community equipment (P1)	Supporting the continuing high level of expenditure beyond BCF and base	Assistive Technologies and Equipment	Community based equipment		350	450	Number of beneficiaries	Social Care		LA			Private Sector	Local Authority Discharge Funding
36	Reablement capacity (P1)	Supporting the continuing high level of expenditure beyond BCF and base	Home-based intermediate care services	Reablement at home (to support discharge)		522.6571891	940.7829405	Packages	Social Care		LA			Private Sector	Local Authority Discharge Funding
37	Residential and nursing care (P3)	Supporting the continuing high level of expenditure beyond BCF and base budgets on care to enable	Residential Placements	Nursing home		10	18	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge Funding
38	D2A Plan (P1)	Home Care or Domicilliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		15500	0	Hours of care	Community Health		NHS			Private Sector	ICB Discharge Funding
39	D2A Plan (P3)	Residential Placements	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	ICB Discharge Funding
40	D2A 7 Day Working	Support for 7 day working	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Acute		NHS			Local Authority	Minimum NHS Contribution
41	CHC Assessor	Support for Continuing Healthcare	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Continuing Care		NHS			Local Authority	Minimum NHS Contribution
42	Neuro Rehabilitation	Support with rehabilitation	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Mental Health		NHS			Local Authority	Minimum NHS Contribution
43	Reablement Capacity (P1)	Supporting the continuing high level of expenditure beyond BCF and base	Home-based intermediate care services	Reablement at home (to support discharge)		522.6571891	0	Packages	Social Care		LA			Private Sector	ICB Discharge Funding

44	Residential and nursing care (P3)	Supporting the continuing high level of expenditure beyond BCF and base	Residential Placements	Nursing home		8.339997302	0	Number of beds/Placements	Social Care		LA			Private Sector	ICB Discharge Funding
45	Discharge Funding (2024-2025) -TBC	TO BE DETERMINED. NCL ICB and LA's plan to agree the final application of the	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Other	<TBC>	<Please Select>			<Please Select>	ICB Discharge Funding

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: Barnet

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	131.2	106.4	133.4	79.0	The ambition is based on the quarterly averages for 2022-2023, overlaid on annualised trends, with a 0.5% reduction assumed due to additional investment in ongoing schemes. Note: The Q4 numbers in the Indicator value are an anomaly, and we have hence used an estimate for the whole year and reduced 0.5% from there	The Access to Care pilot is a new joint initiative between CLCH and the ASC admissions avoidance team, that aims to provide a holistic patient response to reduce unnecessary attendances at A&E, and enable people to receive the care required to remain in their own homes
	Number of Admissions	481	390	489	-		
	Population	395,869	395,869	395,869	395,869		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	130	105	132	122		

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,217.9	2,350.3	2,200.0	Note: The 2022-2023 estimates include a projection for Q4 as Q4 22/23 data is has low diagnostic coding than the usual long stay admissions and is derived from our SUS data that is close to the Public Health Outcomes data shared in the BCF Tempate. The trend for the last four years shows a fluctuation in this metric. Our ambition would therefore be to maintain this metric	We are implementing falls specific interventions in NCL as set out in our narrative plan, alongside further work to increase referrals from care homes and 111 services to our UCR offer.
	Count	1,340	1,329.1	1300		
	Population	56,551	56,551.0	62522		

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	Quarter (%)	92.4%	92.1%	91.5%	92.4%	Given the minimal in-year fluctuation of rates, and that the London rate for 2020-2021 was 92.6%, we are projecting a continuation of 2022-2023 Q1 rates for this	CLCH has deployed nursing staff to care homes to provide clinical input for supported discharge. The new care technology framework will also provide
	Numerator	6,567	6,229	6,328	6,595		
	Denominator	7,108	6,760	6,917	7,140		

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan	metric as a plan.	additional assistive community equipment to enable patients to return home safely with additional monitoring. There is also the establishment of an OT -led reablement approach
	Quarter (%)	92.4%	92.4%	92.4%	92.4%		
	Numerator	6,567	6,567	6,567	6,567		
	Denominator	7,108	7,108	7,108	7,108		

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	543.2	440.9	354.1	345.5	Note: Denominator is incorrect and should be 56551 using the 2021 census data. As current indicators show a significant improvement in performance against 2021-2022 actuals and 2022-2023 plans, our ambition will be to attempt to maintain that performance; as maintaining the same improved count on an increasing population will be a challenge/ However	Development of new extra care schemes and live-in care services in Barnet will enable people to receive higher levels of support within their own home as an alternative to residential admission.
	Numerator	316	269	216	216		
	Denominator	58,170	61,008	61,008	62,522		

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 (%)	77.4%	77.4%	98.7%	98.7%	As current indicators show a significant improvement in performance against 2021-2022 actuals and 2022-2023 plans, our ambition will be to attempt maintain that performance.This improvement is in part due to a change in our approach to	We will continue to review and refine our existing reablement service with a focus on making the best use of our available resources to improve system flows and adequately respond to hospital discharge.
	Numerator	340	340	305	305		
	Denominator	439	439	309	309		

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.

	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
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
	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
	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

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
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
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
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

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
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