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DATE: 27 June 2023

HEALTH AND WELLBEING BOARD

Meeting to be held on Thursday 29 June 2023

Please see the attached report marked "to follow" on the agenda.

7 BETTER CARE FUND PLAN 2023-2025 (Pages 1 - 52)

Copies of the documents referred to above can be obtained from http://cds.bromley.gov.uk/

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Report ACH23-032

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**29 June 2023**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Better Care Fund (BCF) and Improved Better Care Fund (iBCF) 23-25 Plan submission to NHS England**
Contact Officer:	Sean Rafferty, Assistant Director for Integrated Commissioning E-mail: sean.rafferty@bromley.gov.uk
Chief Officer:	Kim Carey, Director of Adult Social Care, London Borough of Bromley Angela Bhan, Place Executive Lead (Bromley,) South East London Integrated Care Board
Ward:	All Wards

1. Summary

This report provides an overview of the Better Care Fund narrative plan and submission process for 2023-25

2. Reason for the report going to Health and Wellbeing Board)

This report provides an overview of the Better Care Fund 2023-25 Plan submission to NHS England. The Health and Wellbeing Board is asked to approve the Plan for submission to NHS England

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

To seek HWB approval for the submission of the BCF 23-25 Partnership Plan to NHS England.

Health & Wellbeing Strategy

1. Related priority: Not Applicable

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1. Cost of proposal: BCF: £60,432k (estimated) for 2023-25; DFG: £5,458k (estimated) for 2023-25 iBCF: £15,460k (estimated) for 2023-25

2. Ongoing costs: BCF: £29,514k (estimated); DFG: £2,885k (estimated); iBCF: £7,730k (estimated)

3. Total savings: N/A

4. Budget host organisation: LBB

5. Source of funding: Section 31 Grant, Ministry of Housing, Communities & Local Government (previously DCLG)

6. Beneficiary/beneficiaries of any savings: London Borough of Bromley and Bromley CCG

Supporting Public Health Outcome Indicator(s)

Not Applicable:

4. COMMENTARY

4.1 Policy Context

4.1.1 The Better Care Fund is one of the government's national vehicles for driving health and social care integration with the intention of supporting local care and health systems in the design and delivery of integrated care and support. The Fund plays an important part in the commissioning and provision of local services.

4.1.2 Launched in 2015, the BCF programme established pooled budgets between the NHS and Local authority, aiming to reduce the barriers created by separate funding streams. The Fund is made up of a combination of contributions from:

- Minimum allocation from integrated care systems (ICS's)
- disabled fund grant-local authority grant
- social care funding (Improved BCF) -local authority
- winter pressures grant funding -local authority grant

4.1.3 In Bromley, the BCF is a pooled fund between the Local Authority and the South East London Integrated Care Board (SELICB Bromley). To draw down the pooled funds the Council and SELICB (Bromley) are required to produce a Better Care Fund plan agreed and monitored by Bromleys Health and Wellbeing Board. The allocation of national funding is subject to an evaluation of the Plan made by NHS England.

4.2 BCF Planning

4.2.1 NHS England publishes each year a policy framework setting out National Conditions, Performance Metrics and Funding arrangements required for each local BCF programme. A key theme of local plans is the designing and delivery of integrated care across health and social care systems. Local systems are also required to agree the alignment between their BCF Plan and relevant Integrated Care Services, with guidance set out on commissioning and delivery at system, place and neighbourhood levels an an ICS design framework.

4.3 Current Partnership Progress with delivery of BCF Metrics in Bromley in 2022/23

4,3,1 The partnership continues to deliver activity and outcomes in line with planned outcomes as set out in the BCF plan for 2022 and detailed in the BCF update for Q4 (2022-23) and detailed below:

Metric	Bromley BCF 22-23 Target	Performance up to Q4 22-23
Avoidable Admissions : unplanned hospitalisation	529	453
Discharge to normal place of residence	93%	93%
Rate of permanent admissions to residential care	410	355
Proportion of older adults (65 and over) who were still at home 91 days after discharge into reablement	93%	93%

4.4 NHS England Planning Requirements for 2023-25

4.4.1 The Government published the Better Care Fund Policy Framework for 2023-25 on 4 April 2023 followed by a set of Better Care Fund Planning Requirements for 2023-25.

4.4.2 This guidance sets out the requirements for implementing the Governments Policy Framework for the Better Care Fund programme for 2023-24 with some furhter guidance for 2024-25 yet to be published. Unlike previous years (where the submission process covered a 1 year period) the current BCF policy framework sets out National Conditions, Metrics, and Funding arrangements for the BCF programmes for 2 years (2023-24 and 2024-25)

4.4.3 The BCF 2023-25 submission plan requires the partnership to report on two new metrics - one on Falls and another on Discharges from Hospital.

4.4.4 The submission to NHS England is to include the completion of a planning template that sets out and details the range of planning, finance and performance data.

4.4.5 The Plan is to be agreed by the local Health and Wellbeing Board and submitted to NHS England by 30 June 2023

5. Bromley BCF Plan 2023-25 Executive Summary

5.1 The BCF Plan shows Bromley's journey of continuous development against the BCF Key lines of enquiry and metrics. This progress is led and supported by sustained collaborative working and effective joint leadership from across the ONE Bromley partnership.

5.2 The 2023-25 Plan progresses further the local delivery against the shared objectives to promote independence and support people living at home for as long as possible, intervening early to prevent deterioration and reduce the need for hospital admissions whilst working together to jointly improve outcomes for people being discharged from hospital. Improvement was shown across all metrics during 22-23 with the end of year review showing improved delivery against all priorities set out in the years Plan.

5.3 Since the 22-23 Plan the ONE Bromley Partnership has developed and agreed in May 2023 the ONE Bromley 5-year strategy which introduces three key priorities to progress joint working and this BCF Plan:

1. Improving population health and wellbeing through prevention and personalised care
2. High quality care closer to home delivered through our neighbourhoods
3. Good access to urgent and unscheduled care and support to meet people's needs

5.4 Key developments from the 2022-23 Plan and significant changes BCF fund allocations for the new Plan include:

- An agreed methodology for population health management has been used to inform the new 5-year plan, and priorities.
- A commitment across partners to develop joint and integrated services at the partnership level with a focus on prevention and early intervention. This builds upon existing neighbourhood services
- A commitment to move more services out of our local hospital and services closers to where people live. Developments such as the establishment of multi-agency Children's Health Hubs are learning from our hospital at home and virtual ward pilots
- The continued development of urgent and unscheduled care services including a new winter plan for 2023-24 – supported through the Hospital Discharge Grant and underpinned by the High Impact Change Model for discharge.

- The introduction of a new Housing with Care Strategy that will review current special housing stock and support and expand provision of extra care and supported living schemes. This will be accompanied a Bromley Housing Assistance Policy as allowed for under the Regulatory Reform (Housing assistance) Order that will better enable the spend of Disabilities Facilities Grant (DFG.)
- A review of how the Better Care Fund, recognised locally as a key vehicle for integration, prevention and improving outcomes for the population, is used to support our plans used to support our plans and objectives
- A review of how the Better Care Fund, recognised locally as a key vehicle for integration, prevention and improving outcomes for the population, will be used to support our plans and objectives

6. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

6.1 The Plan set out local joint care and health arrangements to avoid people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission to hospital. The Plan also details local arrangements to support the discharge of people from hospital.

7. FINANCIAL IMPLICATIONS

The 2023 – 2025 Better Care Fund Plan, including Disabled Facilities grant and the improved Better Care Fund, is set out in the table below. The table also includes the 2022/23 budgets for comparison.

		Scheme Type	Scheme Name	2022/23 Budget £'000	2023/24 Plan Expenditure £'000	2024/25 Plan Expenditure £000'
BCF Minimum ICB Contribution						
	ICB	Assistive Technologies and Equipment	Assistive Technologies	585	585	585
	LBB	Assistive Technologies and Equipment	Assistive Technologies	461	461	461
	ICB	Bed based intermediate Care Services	Intermediate Care Services	1,390	1,390	1,390
	LBB	Bed based intermediate Care Services	Intermediate Care Services	1,286	1,286	1,286
	ICB	Carers Services	Support for carers	576	576	576
	ICB	Community Based Schemes	Risk pool	1,472	1,472	1,472
	Joint	Enablers for Integration	Community and Social Care Development Fund	1,046	1,046	1,046
	LBB	Enablers for Integration	BCF Post	44	44	44
	LBB	Enablers for Integration	Learning Disabilities	27	27	27
	ICB	High Impact Change Model for Managing Transfer of Care	Risk pool	617	617	617
	LBB	High Impact Change Model for Managing Transfer of Care	Risk pool	56	56	56
	ICB	Home Care or Domiciliary Care	Improving healthcare services to Care Homes	343	343	343
	LBB	Housing Related Schemes	Improving healthcare services to Care Homes	457	457	457
	ICB	Integrated Care Planning and Navigation	Assistive Technologies	413	413	413
	LBB	Integrated Care Planning and Navigation	Assistive Technologies	58	58	58
	ICB	Personalised Care at Home	Personalised Support/care at home	678	678	678
	ICB	Personalised Care at Home	Reablement services	1,040	1,040	1,040
	LBB	Personalised Care at Home	Protecting Social Care	10,850	10,850	10,850
	LBB	Personalised Care at Home	Dementia Universal support service	569	569	569
	LBB	Prevention / Early Intervention	Support for carers/assistive technology	1,837	1,837	1,837
	LBB	Reablement in a persons own home	Reablement services	1,276	1,276	1,276
	LBB	Home Care or Domiciliary Care	Discharge to Assess	458	458	458
	LBB	ASC Discharge Fund	Discharge to Assess	992	1,207	1,084
	ICB	ASC Discharge Fund	Discharge to Assess	1,322	1,323	1,323
	ICB	Neighbourhood working development	Neighbourhood working development	0	1,445	2,972
				27,853	**29,514**	**30,918**
DFG						
	LBB	DFG Related Schemes	Disabled Facilities Grants	2,443	2,885	2,573
				2,443	**2,885**	**2,573**
iBCF						
	LBB	Assistive Technologies and Equipment	Equipment	214	214	214
	ICB	Enablers for Integration	D2A staffing	95	95	95
	LBB	Home Care or Domiciliary Care	D2A DomCare	321	321	321
	LBB	Home Care or Domiciliary Care	DomCare	72	72	72
	LBB	Home Care or Domiciliary Care	Whole system reserve	1,677	1,677	1,677
	LBB	Personalised Budgeting and Commissioning	Reducing pressures	4,863	4,863	4,863
	LBB	Residential Placements	D2A Placements	83	83	83
	LBB	Residential Placements	Placements	405	405	405
				7,730	**7,730**	**7,730**
Grand Total				**38,026**	**40,129**	**41,221**

The Better Care Fund Minimum NHS contribution has been uplifted by 5.66% for 2023/24 from 2022/23, and is assumed to be uplifted again by 5.66% for 2023/24. The uplift is currently identified as Neighbourhood Working Development. The allocation between schemes is likely to change during the year in respond to service pressures, and future reports to the Health & Wellbeing Board will advise of any such changes.

Any underspends or unallocated amounts on each project can be carried forward into the next financial year. Quarterly reports are required by government to show the progress of the BCF/IBCF schemes.

8. LEGAL IMPLICATIONS

8.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers.

8.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. For 2017-19 NHS England set the following conditions to access the CCG element of the funding:

8.2.1 The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.

8.2.2 The requirement that Health & Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).

8.3 Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of ICB funding where conditions attached to the BCF are not met, except for those amounts paid directly to local government.

8.4 For 2017-19, NHS England require that BCF plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- NHS contribution to adult social care is maintained in line with inflation;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and
- Managing Transfers of Care

8.4 The Improved Better Care Fund Grant determination is made by the Secretary of State under section 31 of the Local Government Act 2003. The grant may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready and ensuring that the local social care provider market is supported.

8.5 The Council is required to:

- Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption
- Work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19 (revised 2019-20)
- Provide quarterly reports as required by the Secretary of State

Non-Applicable Headings:	TRANSFORMATION/POLICY, PERSONNEL IMPLICATIONS, PROCUREMENT IMPLICATIONS, PROPERTY IMPLICATIONS, CARBON REDUCTION/SOCIAL VALUE IMPLICATIONS, IMPACT ON LOCAL ECONOMY, WARD COUNCILLOR VIEWS
Background Documents: (Access via Contact Officer)	• Better Care Fund Policy Framework for 2023-25 • Better Care Fund Planning Requirements for 2023-25 • Bromley BCF Plan 2022-2023

Appendix 1

Bromley Better Care Fund Plan 2023-2025

Contents

Introduction

The Government's Better Care Fund (BCF) programme supports local health and care systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

This Plan sets out how BCF resources are being used to further health and care joint working in Bromley in 2023-2025. The Plan is approved and overseen by the Bromley Health and Wellbeing Board and submitted to NHS England as part of the BCF Grant conditions. The contents of the Plan are determined by criteria set by the Department for Health and Social Care.

The organisations involved in preparing and delivering on the Bromley Better Care Fund Plan for 2023-24 are:

- London Borough of Bromley (LBB)
- South-East London Integrated Care Board (SELICB)
- Kings College Hospital NHS Foundation Trust
- Bromley Healthcare (community health services provider)
- Oxleas NHS Foundation Trust
- St Christopher's Hospice
- Bromley Third Sector Enterprise (VCS consortium)
- Bromley GP Alliance
- Bromley Primary Care Networks (X 8)

The joined-up approach to integrated, person-centred services across health, care, housing and wider public services in Bromley has, since 1 July 2022, been led by the Bromley Local Care Partnership, the Bromley Place Based Board for the South East London Integrated Care System (SELICS.) This partnership board is supported by the ONE Bromley Executive partnership comprised of senior staff from across local care, health and housing agencies.

This BCF Plan is aligned with and supports the ONE Bromley 5-Year Health and Care Plan which was developed through a series of partnership workshops ran through 2022-23 and consulted on with local community groups, patients groups and residents.

The Plan was agreed by the Bromley Health and Wellbeing Board who have oversight of the plan and will receive a quarterly update on the Plan's progress and achievements against the BCF metric.

Executive Summary

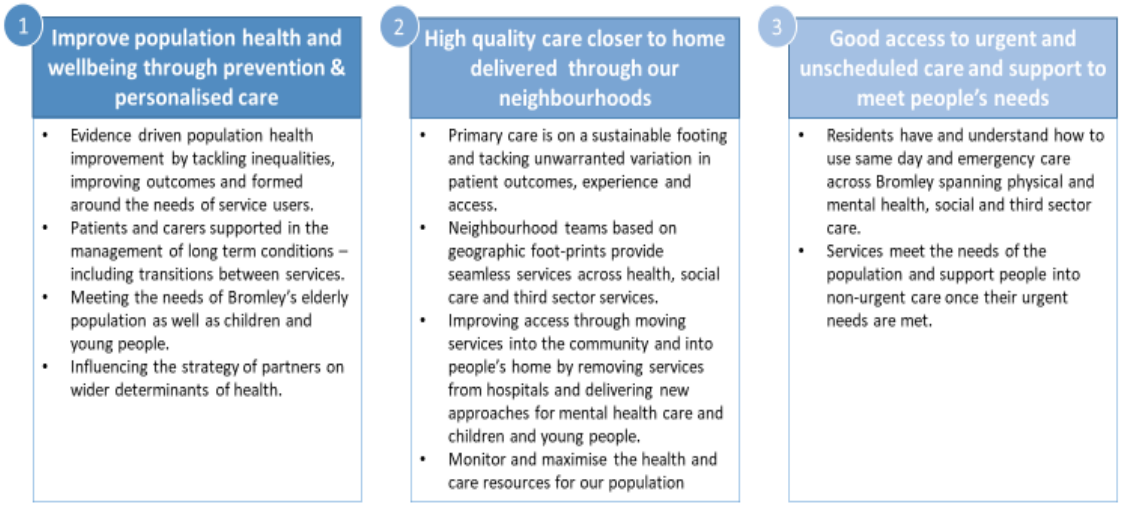
This BCF Plan shows Bromley's journey of continuous development against the BCF Key lines of enquiry and metrics. This progress is led and supported by sustained collaborative working and effective joint leadership from across the ONE Bromley partnership.

The 2023-25 Plan progresses further the local delivery against the shared objectives to promote independence and support people living at home for as long as possible, intervening early to prevent deterioration and reduce the need for hospital admissions whilst working together to jointly improve outcomes for people being discharged from hospital. Improvement was shown across all metrics during 22-23 with the end of year review showing improved delivery against all priorities set out in the years Plan.

Since the 22-23 Plan the ONE Bromley Partnership has developed and agreed in May 2023 the ONE Bromley 5-year strategy which introduces three key priorities to progress joint working and this BCF Plan:

1. Improving population health and wellbeing through prevention and personalised care
2. High quality care closer to home delivered through our neighbourhoods
3. Good access to urgent and unscheduled care and support to meet people's needs

Our strategy in detail



Key developments from the 2022-23 Plan and significant changes BCF fund allocations for the new Plan include:

- An agreed methodology for population health management has been used to inform the new 5-year plan, and priorities.
- A commitment across partners to develop joint and integrated services at the partnership level with a focus on prevention and early intervention. This builds upon existing neighbourhood services

- A commitment to move more services out of our local hospital and services closers to where people live. Developments such as the establishment of multi-agency Children's Health Hubs are learning from our hospital at home and virtual ward pilots
- The continued development of urgent and unscheduled care services including a new winter plan for 2023-24 – supported through the Hospital Discharge Grant and underpinned by the High Impact Change Model for discharge.
- The introduction of a new Housing with Care Strategy that will review current special housing stock and support and expand provision of extra care and supported living schemes. This will be accompanied a Bromley Housing Assistance Policy as allowed for under the Regulatory Reform (Housing assistance) Order that will better enable the spend of Disabilities Facilities Grant (DFG.)
- Plans to recommission housing support for mental health service users including the deregistration of mental health care homes to increase supported living opportunities and an integrated housing support service to be contracted from October 2024
- The extension of pilot arrangements to further increase Direct Payments take up by residents through supporting staff and service users
- Further investments in assisted technology
- A review of how the Better Care Fund, recognised locally as a key vehicle for integration, prevention and improving outcomes for the population, is used to support our plans used to support our plans and objectives

National Condition 1: Overall BCF Plan and approach to integration

Joint priorities for 2023-2025

This BCF Plan 2023-2025 is in alignment with, and in support of, the ONE Bromley 5-Year Plan. In creating the 5-Year Plan the ONE Bromley partners held a series of workshop facilitated by the Kings Fund think tank over a 12-month period. The workshops looked at best practice from across the country and, developed and agreed the population health management approach to determining priorities and the action plans in support of achieving these priorities. The priorities and actions plans were further informed through consultations with patients, services users, carers and community organisations.

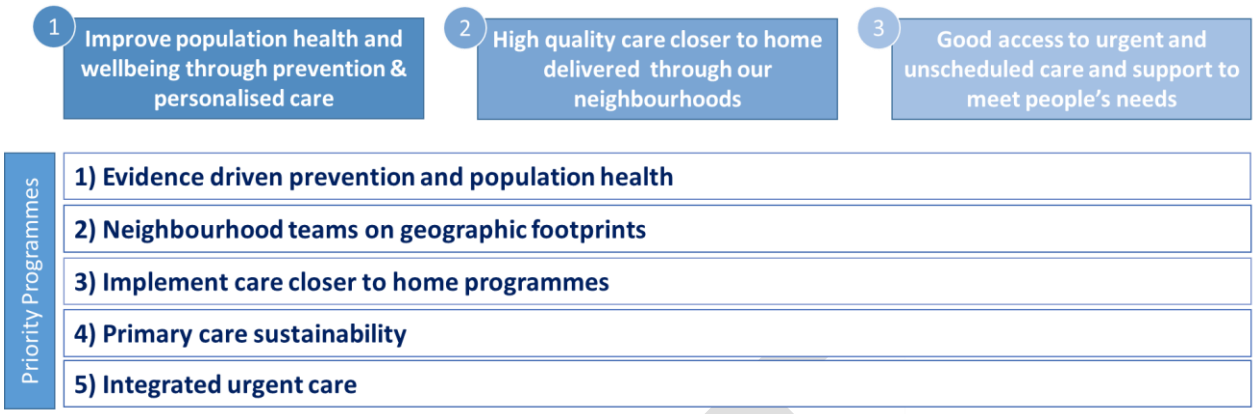
The ONE Bromley Plan is the Place Based contribution to the South East London Integrated Care Service, Joint Forward Plan.

The Three strategic priorities of the ONE Bromley 5 Year Plan, which will inform the BCF activity during 2023-25 are:

1. Improve population health and wellbeing through prevention & personalised care
2. High quality care closer to home delivered through our neighbourhoods
3. Good access to urgent and unscheduled care and support to meet people's needs

The ONE Bromley 5 Year Plan makes a commitment to ensuring that the local authority and ICB finances and resources are used effectively to achieve maximum impact whilst delivering sustainable models of care, that meet population need.

To achieve the 3 strategic priorities of the ONE Bromley Plan, 5 priority programmes have been established. The priorities and programmes are summarised in the table below.



The Joint Priorities, Better Care Fund metrics and National Conditions are incorporated into the operational plans that support the direction and oversight of the 5-Year Plan.

Approaches to joint/collaborative commissioning

In 2020 the Council and the then CCG established an Integrated Commissioning Service with an Assistant Director of Integrated Commissioning appointed as a joint postholder across the CCG (now ICB) and Local Authority. All out of hospital health and care services in Bromley are commissioned through this service. A section 75 agreement totalling £71.5M details specific integrated commissioning and service arrangements.

An Integrated Commissioning Board, jointly chaired between the LBB Director of Adult Services and SELICS Place Executive Lead, leads on the development and oversight of the joint commissioning arrangements. Further oversight is made by the Health and Wellbeing Board with quarterly reports on progress across all joint commissioned programmes and BCF Plan performance.

The Council and ICB intend to develop further this integrated commissioning approach in 2023-24. This will include a focus on joint arrangements for commissioning services to children and young people as well as a further expansion of joint commissioning services for adults, informed by the review of ICB commissioning undertaken in response to the Hewitt Review.

The current services commissioned through the BCF, and priorities for BCF investment in health and care integration include:

- Primary and Secondary Intervention Service contract delivered through the VCS consortium Bromley Third Sector Enterprise – known as the Bromley Well Service. The service provides early intervention, prevention and VCS support service for people meeting a statutory threshold. Through 2023-25 developments will include delivery at neighbourhood level to improve closer working of the VCS and wider services to improve prevention and early help outcomes and strengthen community Assets.
- Significant investment from BCF into the successful integrated hospital discharge pathways including D2A, and the multiagency discharge service and pathways, known locally as the Single Point of Access (SPA). The 2023-25 focus will be in on further enhancing the model using the Hospital Discharge increase funds to the Home First

pathway and to develop integrated teams that support the discharge of patients form hospital to home.

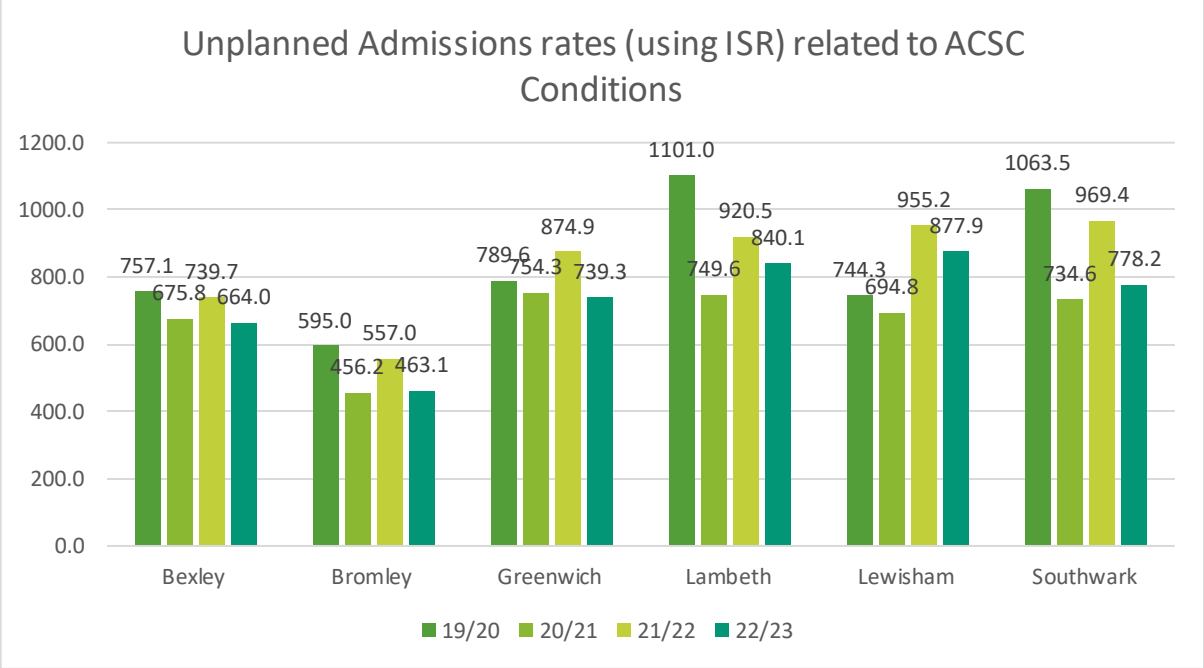
- Consolidate and continuously improve integrated urgent care pathways and effectively deploy BCF Winter pressure funding to manage seasonal demand. This includes consolidating 2 hour and same day health and care emergency services into a single Urgent Community Response (UCR) offer. (Note: UCR services are not currently funded by BCF.)
- BCF continues to fund Extra Care Housing Step-down provision with 3 additional digitally enabled step-down flats mobilised during 21-22. There are now 16 step-down beds.
- A Housing with Care Strategy to review and expand the provision of Extra Care Housing, Supported Living and other specialist housing to vulnerable adults – improving current stock and increasing supply in response to population led demand will be supported by BCF activity during the 23-25
- Significant BCF funding continues to fund the Integrated Community Equipment Contract, with a 2023-24 focus on to mobilising and embedding the recently procured new provider.
- Funding for investment in assisted technology from BCF has been steadily increasing. Through 23-25 the focus will be on continuing to increase the use of assisted technology across health and care services to help more people live in their own home – working with the Social Care Institute for Excellence (SCIE) on improving the user journey and outcomes through digital means
- The social care element of the proactive care pathway is be funded from the BCF. Through 2023-25 there is a commitment, through the ONE Bromley Strategy work, to further expand the Proactive Care pathway delivered through the local Integrated Care Networks, providing proactive care for people living with frailty to prevent deterioration and ensure people can live well until the end of their life. This is directly linked to the local implementation of the Fuller Review recommendations.
- Throughout 2023-24 review of BCF funding there will be a further focus on expanding the commissioning of closer to home services, building on the success of our hospital at home pilots – supporting more people in their own homes and or locating more services in primary and community care settings, e.g. Children's Integrated Hubs being piloted in two PCN areas to be expanded borough-wide – although not funded via BCF.
- Continued funding of integrated support to increase the take up of Direct Payments

In response to the policy shift for BCF and the development of the local 5 Year Strategy, a root and branch review of BCF activity and spend, alongside wider system investment, will be undertaken in Year one of the 2023-25 BCF Plan. The second year of the Plan will enable any transformation work to be undertaken to shift resources accordingly.

Condition 2: Enabling people to stay well, safe and independent at home for longer.

Positive progress is being made on supporting more people to stay well, safe and independent at home in Bromley, with some areas performing the highest in south-east London.

- There has been an ingoing increase in the use of Direct Payments (DP) to 24.9%, up from 18.3% in 21/22, enabling more people to purchase the care they want to meet their needs. A specific Direct Payments for Discharge project was launched in 2022-23, with ongoing focus to continue to increase the number of DPs as a key priority for the Council and the ICB.
- 43% of new adult social care service users who received a short-term service to maximise independence required no ongoing support or support of a lower level showing the positive impact in the short term intervention services offered locally.
- Residents living with frailty continue to be supported through the proactive care pathway via the Integrated Care Networks reducing and preventing deterioration
- There is an ongoing improvement in performance for the number of unplanned admissions to hospital for chronic ambulatory care sensitive conditions from 557 (As a rate per 1,000 of the population), to 463,1 in 22-23 outturn. Bromley continues to be the highest performing borough in SEL on this metric.



- As a result of the ongoing excellent community based support offered locally, the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population has fallen year on year from 477.6 in 20/21 to 335.5 in 22/23, against a backdrop of an increase in the older population locally.

Demand and Capacity

The demand across community services has remained broadly in line with available capacity. Informed by detailed modelling, the current levels of demand in community services have, on the whole, been met through the commissioned capacity.

The voluntary sector offer, commissioned through BCF funding, continues to deliver a comprehensive range of prevention and early intervention services for local residents. Increased demand in some elements of this contract, namely the handyperson service has

been seen, resulting in a planned increase investment in this area during 23-24. The new expanded specification has been mobilised and includes additional resources and support to self-funders, carers and those living with long term conditions.

The demand for Reablement from the community continues to be broadly in line with capacity. Increasing the opportunities and offer of Reablement is a key priority and we expect to increase the number of eligible clients being referred from the community. An ongoing investment in Reablement from the BCF and planned further investment from the Hospital Discharge Fund will further increase the capacity of this service for both community step-up and hospital discharge, giving more people the chance to regain their daily living skills and independence for the best quality of life possible.

To date the occupancy rates across housing with care provision have ensured no waits for people accessing this offer from the community. However modelling shows occupancy rates are increasing alongside an increase in the older and vulnerable adult communities. Two comprehensive demand management projects looking at population trends for older people and for adults with a learning disability have informed the development of a Housing with Care Strategy. The council is soon to publish the strategy which will look to expand the Housing with Care market over the next 10 years, providing a vibrant and diverse housing with care offer to manage the increasing older and vulnerable adult population predictions, mitigating further demand or increase in the use of residential care. This includes some investment in the Extra Care Housing market in the 23-25 Plan, reflected in the hospital discharge section, whilst the wider Housing with Care Strategy is mobilised.

Bromley has a large care home market with 53 registered homes within the borough. The net number of beds has not changed significantly in the last year. However, there is an increase in the luxury market with a reduction in the number of quality, 'affordable' beds available to the Council. There are no instances where clients are required to access more restrictive care then needed. However, during peaks or surges in activity, there may be instances where clients have to wait longer than usual to access residential care and or be placed out of borough. Admissions to care homes from the community have continued in line with projections. The commissioned community offer and integrated working of community health and care teams, continues to enable more people to remain living at home. BCF funding invests in the brokerage service, to ensure sufficient capacity to the brokering of placements and to aid effective management of the market. The local Market Sustainability Plan is focusing on increasing the access to affordable, high quality residential care placements within the borough.

Bromley continues to be the highest performing borough in SEL against the BCF Metric for admissions for people with Ambulatory Sensitive Conditions, which continues to see a year in year improvement. Following the introduction of the Urgent Community Response (UCR) accelerator in 2019, alongside wider investment in integrated community services for people with long term conditions, admissions for ambulatory sensitive conditions have dropped from 2,079 in 19/20, to 1618 in 22/23.

The development of the hospital at home service locally will be a further enhancement to this offer with a focus on respiratory and frailty, the two areas of most activity locally. Although the UCR and integrated community pathways for people with long term conditions are not funded through the BCF, the BCF Funded Bromley Well VCS offer provides social support, advice and guidance for people with long term conditions and their carers. Furthermore, the

investment through the iBCF in social care provision as part of the Local Care Networks and Integrated Care Pathways, ensure clients requiring proactive and emergency access to social care to keep them well in the community is provided. All of which is contributing to reducing unnecessary attendances and admissions to hospital for local residents.

Local approach to enabling people to stay well, safe and independent at home for longer

The strengths-based 'Making Practice Personal', launched in 2020, is Bromley's approach to supporting people in the community through personalised enablement. This new model of practice was implemented with the support of the Social Care Institute for Excellence. The approach brings together practitioners, commissioners and providers to support the transformation of community based services. It is underpinned by the core concepts of the Care Act, ensuring community opportunities, citizenship and personalised outcomes. This systemic approach is underpinned by a culture change and learning and development programme to ensure sustainability with further activity planned with SCIE during 2023-24. The approach builds upon the positive progress made on delivering a strong 'Promoting independence' offer which brings together Reablement, local authority Occupational Therapy services and assisted technologies. The increase in BCF funding to support the use of assisted technologies is having a positive impact on assessment and keeping people safe, enabling people to remain at home living independently. The assisted technology infrastructure will continue to be expanded to reduce the dependence on care and support and will provide an infrastructure in which to utilise more technology across health and care services, including the virtual ward element of the hospital @Home service.

Integrated Care Networks (ICNs), locality based multidisciplinary teams designed to support residents with the most complex care needs to stay well, remain independent and out of hospital where possible, continue to go from strength to strength. Bringing together primary care professionals working to the PCN footprint, the ICNs are enabling people to stay at home with facilitated multi-professional interventions, providing more joined up care for residents. The ICB's current progress on, and initial plans for, developing neighbourhood working have received very positive feedback from Professor Clare Fuller.

Our work to develop the ONE Bromley Strategy highlights many areas of integrated working at a neighbourhood level, and recognises there is more opportunity to develop this further to optimise the wealth of community assets locally. The strategy priority programmes 2) Neighbourhood teams on a geographical footprint and 3) implement care closer to home programmes, will seek to continue to develop localised, integrated working that delivered personalised care, closer to home. Additional, priority programme 1) evidence driven prevention and population health, will support and inform the BCF review to ensure investment is being targeted to areas of evidenced need.

Therefore, during 2023-2025 we will

- Develop our new neighbourhood's approach to integration. This will include ongoing investment in integrated care networks and creating opportunities to further promote neighbourhood working, including developing the capability and capacity for changes with PCNs
- Continue to invest in voluntary sector, early intervention and prevention services including Reablement and Assisted technologies to support people to remain living safe

and well at home. Further increasing this investment and impact wherever possible including opportunities arising from the work with SCIE during 23-24.

- Invest Market Sustainability and Improvement Funds to support domiciliary care contract core providers to take on a larger share of clients, current performance is 28% against a target of 60 -70%
- Develop the trusted assessment role of domiciliary care providers to give greater flexibility and personalisation to help people stay at home
- Build on our progress in growing Direct Payments
- Strengthen and expand the support offer to unpaid carers through a new Carers' Plan and Carer's Charter
- Introduce a Housing with Care Strategy that, over time, will increase access to special housing and improve the current housing stock
- Further develop digital services with a focus on the customer experience and journey from accessing information, advice and guidance through to receiving care in the home

National Condition 3: Provide the right care in the right place at the right time.

In 2022-23 the Bromley Hospital discharge integrated system sustained excellent performance and outcomes including:

- 82% of residents were discharged on the day they no longer need to remain in an acute bed, with the majority of the remaining cohort being discharged the next day.
- 98% of clients receiving reablement/rehabilitation services remained at home 91 days after discharge
- All patients whose chosen place of death is home and were well enough to travel, were discharged home with excellent wrap around health and care to support them at the end of their life to die at home.
- Over 3,500 residents were supported through a broad and diverse voluntary sector offer that supports residents being discharged form hospital.
- The local rehab pathways were some of the highest performing in the country with clients achieving their rehab goals in an average of 22 days for bed based rehab against a national average of 26.6 days and 16 days for home based rehab against a national average of 24 days.
- Friends and family tests tell us 96% of residents receiving a Bromley Health Care Rehab service, would recommend them to a friend or family.

Bromley has continued to improve performance around the number of people being discharged to the normal place of residence BCF metric from 91.9% in 2019-20, to 94.3% in 2022-23. The highest reason currently for patients not being discharged to their normal place of residence, as per the table below, is due to patients being discharged to 'NHS run care home' accounting for 2.6% and patients being 'discharged to another NHS hospital provider – ward for general patients or the younger physically disabled' accounting for 1.8%. Given the demographic of the population, the local priority is to increase the opportunity for residents to receive rehab or a period of convalescence in a non-acute setting, or for patients to be seen in the most suitable environment to meet their needs including being transferred to another NHS setting, therefore discharges to another setting in both of these categories are deemed appropriate. Discharges to a care home straight from hospital have reduced from 72 in 21-22 to 64 in 22-23, with aspirations to reduce this further in 23-24 through the mainstreaming of the Home First model, which is planned to be funded through the Hospital Discharge monies.

Spells	Financial Year				
Discharge Destination	2019/2020	2020/2021	2021/2022	2022/2023	Grand Total
Usual place of residence unless listed below	26,477	23,015	25,721	21,757	96,970
NHS run care home	637	684	735	681	2,737
NHS other hospital provider - ward for general patients or the younger physically disabled	480	474	491	449	1,894
Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establish	306	270	230	170	976
Not known: a validation error	439	43	34	58	574
Non-NHS (other than Local Authority) run care home	64	53	72	64	253
Non-NHS (other than Local Authority) run Hospice	50	50	53	65	218
Not applicable - hospital provider spell not finished at episode end	70	52	40	54	216
NHS other hospital provider - ward for patients who are mentally ill or have learning disabilities	61	48	52	31	192
Non-NHS run hospital	58	35	34	31	158

Demand and capacity

Demand and Capacity for hospital discharge is closely monitored and scrutinised through the Bromley Discharge System Quality Assurance and Performance Management Framework, which is managed through a monthly performance surgery attended by health and care leads and reported to ONE Bromley Executive on a quarterly basis. The integrated discharge function, delivered through the SPA, allows services to be flexed to respond to changing needs of residents throughout the year as well as balancing capacity and demand. Residents are never offered support in a more restrictive setting. Instead health, social care and VCS services are used flexibly to wrap around the needs of the clients, co-ordinated and managed by the Bromley SPA.

Capacity was able to meet demand throughout 2022-23 with clients being discharged into the least restrictive setting possible and all hospital discharge pathways working to a strength based, reablement and recovery ethos. All clients are offered the opportunity to receive rehab or reablement where they meet the criteria, with aspirations to further increase this offer for a wider client cohort during the 2023-25 BCF Plan period. Bromley supported discharges average 875 per quarter with 82% being discharged to pathway 1, 11% to pathway 2 and 7% to pathway 3.

Hospital discharge activity remains broadly consistent throughout the year with an increase in activity and pressure seen during the winter months. The BCF winter funding is used successfully to increase discharge capacity during the winter period, directed by the ONE Bromley Winter Plan which uses as an evidence-based approach to inform winter planning. This will continue throughout the 2023-25 BCF Plan ensuring winter planning and delivery continues to meet local need.

The Discharge to Assess domiciliary care market, which accepts discharges 7 days per week, continues to keep up with demand and also provides capacity to support other pathways where demand is an issue (often caused by staff sickness.) No resident remains in hospital once they are medically fit to leave. Packages of Care (POC) can be arranged and started within 2 hours, providing a robust and responsive offer to hospitals for the discharge or patients.

The Extra Care Housing Discharge to Assess flats have seen a steady throughput with no clients waiting for ECH provision throughout the year. ECH step down accommodation, which is funded through BCF, is also used when a resident is unable to return home temporarily due to maintenance or environmental factors, to enable the client to still be discharged and supported in an independent environment. The 2023-25 Plan aims to further align ECH step down to the SPA to further develop integrated working for clients on this pathway which will expand the range of residents that are able to be supported via Extra Care Housing from hospital, reducing the potential admission to a residential placement. Further expansion of this pathway, with 3 fully connected assisted technology flats funded through hospital discharge monies will support the expected increase in demand as a result of these changes during 2023-24.

Of the pathway three discharges to a placement, 20% are for patients rapidly dying funded under the Fast Track framework or Continuing health Care eligible patients, 41% are for people self-funding their care and the remaining 39% are clients being supported under the adult social care discharge to assess pathway. Pathway three is the only pathway where

there are some delays driven by market availability and/or specialist or complex needs of clients which require a certain environment or skill to manage. The system works hard in these situations to identify and work with providers to achieve the discharge, into a setting that can meet the client's needs. Further work to develop in-borough capacity that can support behaviours that challenge is planned as part of the 2023-25 Plan using Hospital Discharge monies, alongside wider market development activity as part of the adult social care reform.

High Impact Change Model

11%[1] of BCF funding is used to deliver against the High Impact Change Model (HIC) for hospital discharge with all but 1 of the 9 High Impact Change areas achieved. Several areas are delivering at an exemplary level including 'Monitoring and responding to system demand and capacity' and 'multi-disciplinary working'. The further investment of the Hospital Discharge money will take the delivery of Home first and 7 day working from the current 'achieved' to exemplary through the 23-25 Plan.

Further work on the utilisation of the DFG to achieve HIC 9: Housing and related services will be a key priority during 23-25 to ensure this objective is achieved during the plan period.

Impact change	Progress
Change 1: Early discharge planning	Achieved
Change 2: Monitoring and responding to system demand and capacity	Exemplary
Change 3: Multi-disciplinary working	Exemplary
Change 4: Home first	Achieved -working towards Exemplary
Change 5: Flexible working patterns	Achieved -working towards Exemplary
Change 6: Trusted assessment	Achieved
Change 7: Engagement and choice	Achieved
Change 8: Improved discharge to care homes	Achieved
Change 9: Housing and related services	Not yet met

Investment in Hospital Discharge

There continues to be an ongoing and increasing investment form the BCF in hospital discharge services. The named Hospital Discharge Lead and Hospital Discharge co-ordinater, as required by the Hospital Discharge Guidance, are joint funded through BCF, with overall responsibility for hospital discharge across the partnership. This joint leadership continues to deliver strong management and leadership to maintain discharge performance and quality locally and leads ongoing transformation work associated with hospital discharge. This single oversight ensures the system can monitor and respond to pressures,

[1] Not including investment in Discharge to Assess (D2A) services

whilst also ensuring there is no negative impact on any single organisation's finances or resources as a result of hospital discharge activity.

Supporting unpaid carers

Unpaid Carers

The 2021 census identified c.25,000 unpaid carers in Bromley – a drop on previous census results most likely explained because the census took place at the time of lockdown when many caring arrangements were disrupted. Around 4,000 carers are registered with the local Carers' Support Service with c. 9,000 carers registered with GPs.

The local dedicated Carers Support Service was recommissioned in 2022 with Bromley Well and is funded through BCF.

BCF funds enable the following short break and other respite services

- Bromley Dementia Support for people diagnosed with dementia and their carers, including people with early onset dementia.
- Bromley Respite at Home services provides family carers with a break from caring and engages people in activities to help them maintain everyday living skills.

Other Council funding enables a broad respite offer including direct payments to access community services, day services and residential short breaks. A respite and short breaks offer to adults with a learning disability includes a dedicated respite centre including planned and unplanned residential respite along with a menu of community based and home sitting options.

Carers who access the support arrangements report high levels of satisfaction. The National Survey of Adult Carers in England undertaken by NHS England national carers' survey reports for Bromley that:

- 36% of carers were extremely or very happy with the support and services from social services for either the carer or the person cared for
- 71% of carers always or usually felt involved in discussions about support for the person they cared for

However we want more carers to know what support is available through raising awareness of the offer with professions and with residents.

Consultation and coproduction with unpaid carers highlights the following areas for improvement.

- Information, advice and guidance should be more consistent across the agencies that carers go to get their support
- GPs and other health workers are often seen as the first source of advice and could provide more information and advice and signpost carers to the best help from other agencies
- Care and health professionals could share more information with carers on the residents they are caring for
- Care and health workers undertaking assessment should learn more about the lived experience of being a carer
- Clearer information and advice is needed on what respite support is available
- Support to develop long-term and emergency plans would reduce anxiety about situations when carers may be unable to provide care.'

Young carers said:

- Help with education support should be more consistent across schools and college
- At secondary school teachers should know about their young carers' responsibilities and take this into account.

The Council and ICB have developed a new and joint Carers Plan and this will be formally agreed in 2023. The Plan has been informed through consultation events with over 100 unpaid carers, including young carers and draws upon the biennial NHSE survey and other data.

The priorities for the new Plan in 2023-2025 are:

- Identifying, recognising and involving carers
- Making clear routes to information, advice, guidance and support
- Supporting carers' physical health and wellbeing
- Supporting carers to have a life alongside their caring role
- Supporting young carers and young adult carers

A key action in the Plan is the development of a Carers' Charter by the ONE Bromley partnership that will develop a clear and consistent advice and support offer to unpaid carers and support to staff in working to help carers.

Disabled Facilities Grant (DFG) and wider services

There is an undersupply of fully accessible homes to meet demand. This is being addressed in three ways. Firstly, by ensuring through planning conditions that new developments include a proportion of accessible homes, secondly by adaptation of existing homes, and thirdly by ensuring that our own programme of new build developments contains a proportion of accessible homes.

Our approach recognises that adaptations have a critical role in:

- supporting older people, disabled people, young disabled children and their carers to manage their health and wellbeing in the home, reducing and delaying the need for further care and support
- extending safe, independent living in the home and delaying moves into residential care
- efficient, cost-effective delivery of health and care services within the home
- reducing demand for NHS services/ reducing people delayed in hospital while awaiting home adaptations
- prevention of high-cost acute incidents, such as falls and other hazards in the home.

A Disabled Facilities Grant Panel takes forward this approach and includes representatives from Housing, Social Care and Occupational Therapy professionals. The panel considers applications for Disabled Facilities Grants which are then administered and delivered by Bromley's Housing Improvement Team. Social Care and Occupational Therapy staff work closely with Health colleagues in identifying where changing health and care needs necessitate specialist equipment and/or adaptations to be made in order to support people to remain in their own home

The Council has two specialist Housing Occupational Therapists. Their role is threefold. They assess the needs of Housing Register applicants that require Accessible/Adapted

housing; they assess the accessibility and adaptability of void properties so they can be successfully matched to the needs of applicants, and; they inform the process of new build developments to ensure accessible properties are built to correct standards.

We have improved liaison between Housing Services, OT, and Social Care via joint working at a senior level to ensure needs of high profile cases are met. We also improved liaison with health around hospital discharge through relationships and pathways developed in response to the Covid pandemic.

Within the Council a monthly High Need Cases Panel ensures the best use of available housing resources and to ensure that we can respond quickly to changes in circumstances. This year we also plan to introduce quarterly reviews of high need cases across Housing, Social Care and OT.

The Council is reviewing its approach to housing improvement in line with the Statutory Guidance on DFG delivery issued by DLUHC, RCOTs guidance adaptations without delay and internal policy consultation with partners and residents. We are in the process of developing our local Housing Assistance Policy as allowed for under the Regulatory Reform (Housing assistance) Order. Giving greater flexibility in supporting the wider housing and health hazards arising in peoples home often resulting in hospitalisations. The new policy will deliver a suit of grants and loans outside of the mandatory guidelines cantered on housing and health. To achieve this we have had extensive discussions with our housing and enforcement colleagues to ensure the grants are targeted to achieve the best possible outcomes. We are also address within this policy the lack of adapted and adaptable properties by working with our social registered providers to ensure properties being disposed of by RSLs at auction due to repair cost are kept within the social sector where these properties are suitable for adaptation. The new policy will help take forward the spend of accrued funds.

Our policy will include top up and discretionary funding to Mandatory DFG and include grants for energy efficiency, eradication of Cat 1 hazards as described by the Housing Act 2004 and Nuisance as Described in the Environmental Protection Act 1990.

There will be a landlord element to bring back empty properties and security and safety and to ensure Minimum energy efficiency standards are met as well working with them to ensure their homes are adapted where they have tenants requiring this.

Additional information (not assured)

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

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£3M

Equality and health inequalities

Demographic Profile

The update of the demographic profile for our Joint Strategic Needs Assessment (JSNA) made in 2021 has highlighted the following issues with regards to population changes and health equalities and inequalities for people with protected characteristics under the Equality Act 2010:

- The latest (2021) estimate of the resident population of Bromley is 330,379, having risen by 27,705 since 2001.
- The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.8% of the population in 2021 to 18.7% by 2025 and 20.2% by 2031.
- The latest (2021) GLA population projection estimates show that 21% of the population is made up of Black, Asian and minority ethnic groups, this is expected to increase to 24% by 2031
- The ethnic minority group experiencing the greatest increase within Bromley's population is the Black African community, with an increase in the population size of 16.6% by 2026 and 29.5% by 2031 when compared to 2021
- Internal and international migration into Bromley is decreasing by year (2015-2019). There has been a net emigration out of Bromley since 2015. Since 2016 the main contributor to an increase in population is natural births rather than migration into Bromley.
- North West and North East Bromley have the highest levels of deprivation, whilst Central and South Bromley have much lower levels.

From the 2011 Census data we can predict the number of people who have a disability or long-term health problem that limits their day-to-day activities a lot or a little (Table 13). From the Census it was calculated that 7% of residents in Bromley had a disability or long-term health condition that effected their day-to-day activities a lot, 8% said they were affected a little by their disability or condition. These percentages are similar to the London average, but less than the proportion in England

The top 5 causes of years lived with disability in Bromley has remained the same from 2009 to 2019. This includes musculoskeletal disorders, mental disorders, other non-communicable diseases, neurological disorders, and diabetes & CKD. There has been an increased impact to years lived with disability caused by unintentional injury, digestive diseases, and nutritional deficiencies. There has been a decrease in the impact caused by chronic respiratory diseases, cardiovascular diseases and maternal & neonatal diseases

One of the main burdens of disability in Bromley is mental health disorders. The estimated prevalence of common mental health disorders in Bromley is 15.1% for 16+ years and 9.1% for 65+ years (PHE: Fingertips, 2017). People with a learning disability have a shorter life expectancy. This is due to them being disproportionately affected by certain health conditions including coronary heart disease, respiratory disease and epilepsy. Bromley Quality Outcomes Framework (QOF 2020/21) prevalence of learning disabilities is 0.3%, approximately 1191 people.

NHS Health Check Equity Audit- Years 2018, 2019-20 and 2021-22

The Council's Public Health Service has conducted a series of audits on equity for NHS checks. The key areas examined were number (%) of eligible people invited for NHS Health Checks, number (%) of checks completed and any differences by age, gender, ethnicity and GP practice.

Results of these audits are positive, particularly in that we have consistently not found an inequity in terms of ethic groups. Also, there has been an improvement in the proportion of younger people (45-54) completing the check. However, the variation between the GP practices has not improved over time.

Actions following the audits have included engagement with GP practices – Public Health nurses visited individual practices and discussed their specific issues. Support and advice were offered to several practices. Further engagement and training will be provided to GP practice as well as continuous support.

Health Inequality Projects

ONE Bromley 5-Year Plan health inequalities priorities including priority actions for Core20PLUS5 include the following schemes that commenced in 2022-23.

Orpington and Crays Frailty Hubs/Cafes – Designed with local residents services include cafes, social activities, healthcare talks and healthy food working. Health checks at the cafes are identifying patients with underlying conditions who have previously not been known or engaged with healthcare services. The learning from these pilots is informing the introduction of similar hubs across the Borough.

Homeless Project - An integrated team, including the GPs, mental health services, drug and alcohol services, are running healthcare clinics for people in the local Homeless Shelter. The project is addressing the health inequalities and barriers to accessing health services faced by this population. The service is now operational with outcomes being measured.

Pro-active Care Case Management Pilot - Care for patients who have been pro-actively identified, include high-users of healthcare with complex needs. A case management team ensures that actions are followed up from a holistic review. Once completed, these patients are handed back into the care of their GP practice and a Care Navigator. The outcomes being monitored are reduction in the patients immediate health and care needs across the system, such as a reduction in escalation to hospital emergency and elective services. Patients have now been identified and are under the care of the case management team. The learning from this pilot will be used to inform models on a Borough wide basis.

PCN Housebound patients projects - These projects reach out to these patients, identifying this most at risk and visiting the patients at home to review their needs. This results in reducing the social inequalities for this cohort of patients who are generally more isolated and improving their health outcomes and chronic disease management.

In 2023-24 new health inequalities projects will include establishing of a Health and Well Being Hub in the Bromley Town Centre Shopping Centre, offering vaccinations, NHS Health Checks, signposting to screening, cost of living advice and health and lifestyle advice.

Bromley Health & Wellbeing Strategy 2024 – 2030

Work began in 2022 on preparing the Borough's new Health and Wellbeing Strategy for implementation from 2024. The Health & Wellbeing Board has agreed the following three overarching priorities to inform this work:

1. Improving Health and Wellbeing of young people (to include obesity, youth violence, adolescent mental health).

2. Improving Health and Wellbeing of Adults (to include obesity, diabetes, dementia, mental health, substance misuse).

3. Disease prevention and helping people to stay well (linking with our ICB prevention priority and achieving this through our vital 5 work).

The strategy and its action plan will be completed in time for 2024.

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 of each type of output and the units it will prepopulate with is viewable 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 1.0.0

Please Note:

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

		Complete:
Health and Wellbeing Board:	Bromley	Yes
Completed by:	ola akinlade	Yes
E-mail:	ola.akinlade@bromley.gov.uk	Yes
Contact number:	0208 313 4744	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Daviud	Jefferys	david.jefferys@bromley.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Andrew	Bland	andrew.bland@selondonics.nhs.uk	Yes
	Additional ICB(s) contacts if relevant	Dr	Angela	Bhan	angela.bhan@selondics.nhs.uk	Yes
	Local Authority Chief Executive	Mr	Ade	Adetosoye	ade.adetosoyece@bromley.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Kim	Carey	kim.carey@bromley.gov.uk	Yes
	Better Care Fund Lead Official		Sean	Rafferty	sean.rafferty@bromley.gov.uk	Yes
	LA Section 151 Officer		Peter	Turner	peter.tuner@bromley.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->			kelly	sylvester	kelly.sylvester@bromley.gov.uk	

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	No

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Bromley

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,572,564	£2,572,564	£2,572,564	£2,572,564	£0
Minimum NHS Contribution	£26,984,180	£28,511,485	£26,984,180	£28,511,485	£0
iBCF	£7,730,511	£7,730,511	£7,730,511	£7,730,511	£0
Additional LA Contribution	£435,083	£0	£435,083	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,083,806	£1,083,806	£1,083,806	£1,083,806	£0
ICB Discharge Funding	£1,323,000	£1,323,000	£1,323,000	£1,323,000	£0
Total	**£40,129,144**	**£41,221,366**	**£40,129,144**	**£41,221,366**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£7,668,138	£8,102,155
Planned spend	£8,988,490	£10,515,795

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£16,324,593	£17,248,565
Planned spend	£19,234,180	£20,761,485

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	130.0	128.0	128.0

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	1,888.0	2,097.8
	Count	1197	1331
	Population	58536	61274

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%	93.5%	93.5%	93.5%

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	332	366

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 (%)	96.5%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	
NC3: NHS commissioned Out of Hospital Services	**PR5**	
NC4: Implementing the BCF policy objectives	**PR6**	
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: Bromley

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 social 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 (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
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Other short term social care
- 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 5 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement or rehabilitation at home
- Other short-term social care
- 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.	Note the UCR element includes Rapid Response, Rapid Access to Therapy and Urgent Falls. he Trust pathway flow trajectories have been noted alongside the actual SitRep data to give boroughs the Trust view of flow (organge tab). To note there are differences between the actual flow reported compared with the 2024/25 trajectories. There are a number of reasons for this, one could be that the Trusts have looked at a different time period than the six months used to produce the trajectories. The demand figures are estimates based on averages over a 12 month period and the split between reablement and rehab demand are estimates as well based on 50:50 split across reablement and rehab

	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

KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	280	290	306	275	280	300	296	297	291	280	288	300
OTHER		17	23	11	15	17	42	17	23	14	12	15	14
OTHER		297	313	317	290	297	342	313	320	305	292	303	314
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Reablement at home (pathway 1)	15	15	15	20	20	25	15	20	25	22	20	25
OTHER		3	3	3	3	3	4	3	4	4	4	3	3
OTHER													
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	50	50	50	50	50	50	55	60	55	60	60	50
OTHER		10	10	10	10	10	10	10	10	10	10	10	10
OTHER													
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	3	3	3	3	3	3	3	3	3	3	3	3
OTHER													
OTHER													
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	9	9	9	9	9	9	9	9	9	9	9	9
OTHER		2	2	2	2	2	2	2	2	2	2	2	2
OTHER													
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Other short term social care (pathway 1 & 2)	80	110	90	90	80	110	100	70	110	125	70	100
OTHER		10	10	10	10	10	10	10	10	10	10	10	10
OTHER													
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	14	16	15	13	12	10	12	8	16	14	8	15
OTHER		2	2	2	2	2	2	2	2	2	2	2	2
OTHER													

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)	833	833	833	833	833	833	833	833	833	833	833	833
Urgent Community Response	862	862	862	862	862	862	862	862	862	862	862	862
Reablement at home	65	65	65	65	65	65	65	65	65	65	65	65
Rehabilitation at home	112	112	112	112	112	112	112	112	112	112	112	112
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	36	36	36	36	36	36	36	36	36	36	36	36
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 support (including VCS)	Monthly capacity. Number of new clients.	330	330	330	330	330	345	345	345	345	345	330	330
Reablement at Home	Monthly capacity. Number of new clients.	20	20	20	20	25	30	30	30	30	30	30	30
Rehabilitation at home	Monthly capacity. Number of new clients.	60	60	60	60	60	70	70	70	70	70	60	60
Reablement in a bedded setting	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	3	3
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	12	12	12	12	12	12	16	16	16	16	12	12
Other short term social care	Monthly capacity. Number of new clients.	95	95	95	95	85	95	115	115	115	130	100	110
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	20	20	20	20	20	20	20	20	20	20	20	20

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

ICB	LA	Joint
20%	80%	
	100%	
100%		
100%		
	100%	
20%	80%	

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.	833	833	833	833	833	833	833	833	833	833	833	833
Urgent Community Response	Monthly capacity. Number of new clients.	862	862	862	862	862	862	862	862	862	862	862	862
Reablement at Home	Monthly capacity. Number of new clients.	45	45	45	45	45	45	45	45	45	45	45	45
Rehabilitation at home	Monthly capacity. Number of new clients.	112	112	112	112	112	112	112	112	112	112	112	112
Other short-term social 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.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	4	4	4	4	4	4	4	4	4	4	4	4

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

ICB	LA	Joint
100%		
	100%	
100%		
100%		

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Bromley

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Bromley	£2,572,564	£2,572,564	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£2,572,564**	**£2,572,564**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Bromley	£1,083,806	£1,083,806	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS South East London ICB	£1,323,000	£1,323,000	Yes
Total ICB Discharge Fund Contribution	£1,323,000	£1,323,000	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Bromley	£7,730,511	£7,730,511	Yes
Total iBCF Contribution	**£7,730,511**	**£7,730,511**	

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

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
Bromley	£311,652	£0	DFG Carry over	
Bromley	£123,431	£0	ASC discharge fund carry over	Yes
Total Additional Local Authority Contribution	**£435,083**	**£0**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS South East London ICB	£26,984,180	£28,511,485
Total NHS Minimum Contribution	**£26,984,180**	**£28,511,485**

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

Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
		£0	
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£26,984,180**	**£28,511,485**	

Yes

	2023-24	2024-25
Total BCF Pooled Budget	**£37,722,338**	**£38,814,560**

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

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Bromley

<< 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	£2,572,564	£2,572,564	£0	£2,572,564	£2,572,564	£0
Minimum NHS Contribution	£26,984,180	£26,984,180	£0	£28,511,485	£28,511,485	£0
iBCF	£7,730,511	£7,730,511	£0	£7,730,511	£7,730,511	£0
Additional LA Contribution	£435,083	£435,083	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£1,083,806	£1,083,806	£0	£1,083,806	£1,083,806	£0
ICB Discharge Funding	£1,323,000	£1,323,000		£1,323,000	£1,323,000	£0
Total	**£40,129,144**	**£40,129,144**	**£0**	**£41,221,366**	**£41,221,366**	**£0**

Required Spend

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

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,668,138	£8,988,490	£0	£8,102,155	£10,515,795	£0
Adult Social Care services spend from the minimum ICB allocations	£16,324,593	£19,234,180	£0	£17,248,565	£20,761,485	£0

Checklist

Column complete:

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

>> 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, 102, 103, 104, 105, 106, 107, 108, 109, 110

									Planned Expenditure									
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Enhanced Care	Live in and enhanced care and MDT to support a ful Hime First Offer	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		Joint	73.0%	27.0%	Private Sector	ICB Discharge Funding	Existing	£726,194	£726,194	2%
2	Discharge to Assess Beds	3 nursing home beds for complex clients supported by the enhanced care MDT and	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		Joint	50.0%	50.0%	Private Sector	ICB Discharge Funding	New	£120,000	£120,000	0%
3	Additional ToC Capacity -7-day working	2 WTE discos to support increased bed base and 7 day working	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Acute		NHS			NHS Acute Provider	ICB Discharge Funding	New	£120,000	£120,000	0%
4	Mental Health Complex Case Lead	Specialist MH Complex Case Lead to support timely discharge of mental health	Workforce recruitment and retention						Mental Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£71,300	£71,300	0%

5	Hospital 2 Home	2 x clinical care co-ordinators to manage the transition from hospital to safely living	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£80,000	£120,000	0%
6	Equipment	to fund additional requests for equipment to support discharge	Assistive Technologies and Equipment	Other	Number of devices	553	553	Number of beneficiaries	Other	equipment	LA			Local Authority	ICB Discharge Funding	New	£155,102	£155,102	0%
7	Care Home Support Offer	Expand the Dementia Care Home Support Team offer to support care homes	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding	Existing	£50,404	£10,404	0%
8	D2A Staffing	staffing	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			Local Authority	iBCF	Existing	£95,000	£95,000	0%
9	Equipment	Assistive Technology	Assistive Technologies and Equipment	Community based equipment		7000	7000	Number of beneficiaries	Social Care		LA			Private Sector	iBCF	Existing	£214,000	£214,000	1%
10	Dom Care	Dom Care Packages	Home Care or Domiciliary Care	Domiciliary care packages		3000	3000	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£72,000	£72,000	0%
11	Placements	Learning Disability Placements	Residential Placements	Learning disability		207	207	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£405,460	£405,460	1%
12	D2A Placements	Discharge to Assess Pathway	Home-based intermediate care services	Rehabilitation at home (to prevent admission to hospital or residential care)	Discharge from Hospital with Reablement	216	216	Packages	Community Health		LA			Private Sector	iBCF	Existing	£83,000	£83,000	0%
13	D2A Dom Care	Dom Care Support	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Private Sector	iBCF	Existing	£321,000	£321,000	1%
14	DFG	Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		250	300	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG	Existing	£2,572,564	£2,572,564	6%
15	Intermediate Care Services	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			Private Sector	Minimum NHS Contribution	Existing	£1,123,000	£1,123,000	3%
16	Intermediate Care Services	bed based step up	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support admissions avoidance)					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£706,000	£706,000	2%
17	Assistive Technology	Care Planning and Navigation	Assistive Technologies and Equipment	Other	Care Navigation and Planning	938	938	Number of beneficiaries	Other	Voluntary Sector	NHS			NHS	Minimum NHS Contribution	Existing	£413,000	£413,000	1%
18	Assistive Technology	Joint Assessment Teams	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£58,000	£58,000	0%
19	Intermediate Care Services	bed based care step down	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support admissions avoidance)					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£684,000	£684,000	2%
20	Assistive Technology	Community Based Equipment	Assistive Technologies and Equipment	Community based equipment		1773	1773	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£461,000	£461,000	1%
21	Personalised Support/Care at Home	Dementia Universal support service	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£569,000	£569,000	1%
22	Personalised Support/Care at Home	Mental Health Support	Personalised Care at Home	Mental health /wellbeing					Mental Health		NHS			NHS	Minimum NHS Contribution	Existing	£678,000	£678,000	2%
23	Improving Healthcare service to Care	Housing	Other						Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£457,000	£457,000	1%
24	Improving Healthcare service to Care	Dom Care	Home Care or Domiciliary Care	Domiciliary care packages		14291	14291	Hours of care	Other	Voluntary Sector	NHS			NHS	Minimum NHS Contribution	Existing	£343,000	£343,000	1%
25	Support for carers /assistsive technology	Support for Carers	Prevention / Early Intervention	Other	support for Carers				Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£1,837,000	£1,837,000	5%
26	Risk Pool	Community Health Schemes	Other						Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,472,000	£1,472,000	4%
27	Risk Pool	Discharge Planning	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£56,000	£56,000	0%
28	Personalised Support/Care at Home	Social Care Support	Personalised Care at Home	Physical health/wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£10,850,000	£10,850,000	27%
29	Support for carers	carers support	Carers Services	Respite services		75	75	Beneficiaries	Other	Voluntary Sector	NHS			NHS	Minimum NHS Contribution	Existing	£576,000	£576,000	1%

30	Reablement	Reablement Support	Home-based intermediate care services	Rehabilitation at home (to support discharge)		45	45	Packages	Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,040,000	£1,040,000	3%
31	Reablement	Reablement Support	Home-based intermediate care services	Reablement at home (to support discharge)		45	45	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,276,000	£1,276,000	3%
32	Intermediate Care Services	Discharge to Assess Pathway	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Other	Private sector	LA			Private Sector	Minimum NHS Contribution	Existing	£163,000	£163,000	0%
33	BCF Post	commissioning infrastructure	Other						Other	Joint Commissioning Infrastructure	LA			Local Authority	Minimum NHS Contribution	Existing	£44,000	£44,000	0%
34	Assistive Technology	Assistive Technology	Other						Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£585,000	£585,000	1%
35	Learning Disability	Governance arrangements	Enablers for Integration	New governance arrangements					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£27,000	£27,000	0%
36	Single Point of Access	integrated Hospital Hub	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£1,046,000	£1,046,000	3%
37	Reducing pressures	Social Care Support	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	iBCF	Existing	£4,863,051	£4,863,051	12%
38	whole system reserve	Social Care Support	Other						Social Care		LA			Private Sector	iBCF	Existing	£1,677,000	£1,677,000	4%
39	D2A packages	D2A packages	Other						Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£457,690	£457,690	1%
40	High Impact Model	High impact model	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£617,000	£617,000	2%
41	additional DFG	adaptations	Other						Social Care		LA			Local Authority	Additional LA Contribution	New	£311,652	£0	0%
42	additional LA	additional discharge funding	Other						Social Care		LA			Local Authority	Additional LA Contribution	New	£123,431	£0	0%
43	Neighbourhood Working Development	Neighbourhood development	Community Based Schemes	Integrated neighbourhood services					Social Care		NHS			NHS	Minimum NHS Contribution	New	£1,445,490	£2,972,795	5%
44	Enhanced Care	Live in and enhanced care and MDT to support a ful Home First Offer	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		13212	11408	Hours of care	Social Care		Joint	27.0%	73.0%	Private Sector	Local Authority Discharge	Existing	£317,089	£273,806	1%
45	Discharge to Assess Beds	3 nursing home beds for complex clients supported by the enhanced care MDT and	Residential Placements	Nursing home		7	7	Number of beds/Placements	Social Care		Joint	50.0%	50.0%	Private Sector	Local Authority Discharge	New	£120,000	£120,000	0%
46	Equipment	to fund additional requests for equipment to support discharge	Assistive Technologies and Equipment	Other	community equipment	383	383	Number of beneficiaries	Other	equipment	Joint	61.0%	39.0%	Private Sector	Local Authority Discharge	New	£99,586	£99,586	0%
47	Deep Cleans and furniture moves	Cleans and furniture moves to enable safe hospital discharge	Care Act Implementation Related Duties	Other	deep cleans				Social Care		LA			Private Sector	Local Authority Discharge	Existing	£50,000	£50,000	0%
48	shopping	funding for shopping for clients unable to access their finances going through Court	Care Act Implementation Related Duties	other	shopping				Social Care		LA			Charity / Voluntary Sector	Local Authority Discharge	New	£5,000	£5,000	0%
49	ECH	3X ech , AT enabled step down flats to support hospital discharge	Residential Placements	Supported housing		62	62	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge	Existing	£57,131	£57,131	0%
50	ECH	ECH Care Manager	Other	Supported housing					Social Care		LA			Private Sector	Local Authority Discharge	Existing	£65,000	£65,000	0%
51	Assistive Technology	increase use of AT to support discharge	Other						Social Care		LA			Local Authority	Local Authority Discharge	New	£50,000	£50,000	0%
52	Reablement	increase in capacity from 30 to 45 on the caseload including a double handed	Care Act Implementation Related Duties	Other	reablement				Social Care		LA			Local Authority	Local Authority Discharge	New	£320,000	£363,283	1%

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 admissions avoidance) 3. Bed-based intermediate care with rehabilitation to support discharge) 4. Bed-based intermediate care with reablement (to support admission 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 beds/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: Bromley

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	129.3	117.2	129.9	110.0	The indicator values are based on a 4 year trend (2019-20 to 202-23) with an average of 517 Avoidable admissions per year over a 4 year period. While we have experienced a downward trend over the 4 year period more recent performance shows slight increase in figures With this in mind we plan to maintain our good	Consolidation of the effective admission avoidnace services across health and social care into a single Urgent Community Response offer with ongoing expansion of the hospital @Home service, with a focus on frailty and respiratory conditions, expexted to further support the reduction in admissions for ambulatory sensitive	Yes
	Number of Admissions	459	416	461	-			
	Population	332,336	332,336	332,336	332,336			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	130	130	128	128			Yes

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,124.2	1,888.0	2,097.8	The 23-24 plan is based on the trajectory of falls activity from the Falls direct standardisation calculation 2020 -2023 data provided by NHSE and corroborated by SEL analytics providing this data via the BCF dashboard	Mainstreaming the home first offer to enable all residents, where it is safe to do so, to return home.	Yes
	Count	1,350	1197	1331			Yes
	Population	58,356	58536	61274			Yes

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.4%	92.8%	93.5%	93.3%	Based on 3 year trajectory overlayed with implications of population growth and mitigation achieved from hospital dischare and BCF monies investment	Ongoing positive work to reduce the number of people discharged from hospital to a care home through the mainstreamed Home First offer. Further move to neighbourhood working with expansion of pro-active care for people living with frailty to interveign early and reduce the pace of deterioration and improve the outcomes of	Yes
	Numerator	6,111	5,885	5,769	5,718			
	Denominator	6,546	6,341	6,172	6,130			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	93.5%	93.5%	93.5%	93.5%			
	Numerator	6,342	6,342	6,342	6,342			Yes

	Denominator	6,785	6,785	6,785	6,786		individuals able to live independently at home for longer. Expanding the housing	Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	332.1	410.8	410.8	366.1	Based on 3 year trajectory	Continued successful work to reduce the number of people discharged from hospital to a care home through the mainstreamed Home First offer, funded through Hospital Discharge monies. Furthermore the move to neighbourhood working and expansion	Yes
	Numerator	193	244	244	220			Yes
	Denominator	58,115	59,389	59,389	60,085			

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 (%)	99.5%	93.0%	98.6%	96.5%	Projections are based on analysis of 3 year trend taking into account the increase in capacity being inroduced during 23-24 with the further investment from Hospital Discharge Monies which will enable support to a more complex group of clients	The current challenge for Reablement is to increase capacity within the service. This is being worked on with the introduction of a new rostering system and recruitment drive to increase the FTE of reablement support workers enabling more provision	Yes
	Numerator	370	493	283	382			Yes
	Denominator	372	530	287	396			Yes

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

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

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Bromley

	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	See pages XX, XX and XX			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	See pages XX, XX and XX			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	See pages XX, XX and XX			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	<Please Select>				No
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	<Please Select>				No

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	<Please Select>				No
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	<Please Select>				No

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	See pages XX, XX and XX			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