Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

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Completed by:	Katy Dunne	
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Contact number:	Teams	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Thu 07/09/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
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Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Nottinghamshire

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£7,886,632	£7,886,632	£7,886,632	£7,886,632	£0
Minimum NHS Contribution	£68,512,792	£72,390,616	£68,512,792	£72,390,616	£0
iBCF	£30,920,338	£30,920,338	£30,920,338	£30,920,338	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£4,334,983	£4,334,983	£4,334,983	£4,334,983	£0
ICB Discharge Funding	£3,778,085	£3,778,085	£3,778,085	£3,778,085	£0
Total	**£115,432,831**	**£119,310,655**	**£115,432,830**	**£119,310,654**	**£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£19,469,393	£20,571,361
Planned spend	£39,114,008	£41,327,861

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£26,596,932	£28,102,319
Planned spend	£26,596,932	£28,102,319

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)	201.3	181.7	194.7	192.6

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	1,887.0	1,887.0
	Count	3320	3320
	Population	176230	176230

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	92.5%	93.0%	94.0%

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	577	532

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 (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes

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

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Nottinghamshire

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

3.1 Demand - Hospital Discharge

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

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

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

3.2 Demand - Community

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

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

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

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

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

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Demand from Hospital Discharges The ICS report on the number of discharges from acute hospitals using data direct from Nervecentre. Hospital discharges from between April 2022 and March 2023 have been used to set the baseline number in the draft return. No growth assumption has been applied to this baseline figure. For the draft return no phasing has been applied with all months equal. The same baseline period has been taken for patients discharged from a Mental Health in-patient bed and these are also included in the return based on the discharge destination. It has been assumed that 20% of

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

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

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST		0		0	0	0	0	0	0	0	0	0	0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		0											
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		0											
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		0											
OTHER		0											
(Please select Trust/s.....)	Reablement at home (pathway 1)												
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST		44	44	44	44	44	44	44	44	44	44	44	44
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		302	302	302	302	302	302	302	302	302	302	302	302
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		12	12	12	12	12	12	12	12	12	12	12	12
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		170	170	170	170	170	170	170	170	170	170	170	170
OTHER		29	29	29	29	29	29	29	29	29	29	29	29
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)												
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST													
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST													
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST													
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST													
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST													
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST													
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
OTHER		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST		19	19	19	19	19	19	19	19	19	19	19	19
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		79	79	79	79	79	79	79	79	79	79	79	79
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		15	15	15	15	15	15	15	15	15	15	15	15
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		41	41	41	41	41	41	41	41	41	41	41	41
OTHER		8	8	8	8	8	8	8	8	8	8	8	8
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST		9	9	9	9	9	9	9	9	9	9	9	9
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		24	24	24	24	24	24	24	24	24	24	24	24
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		7	7	7	7	7	7	7	7	7	7	7	7
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		32	32	32	32	32	32	32	32	32	32	32	32
OTHER		4	4	4	4	4	4	4	4	4	4	4	4
Totals	**Total:**	795.088333	795.088333	795.088333	795.088333	795.088333	795.088333	795.088333	795.088333	795.088333	795.088333	795.088333	795.088333

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)	150	150	150	150	150	150	150	150	150	150	150	150
Urgent Community Response	0	0	0	0	0	0	0	0	0	0	0	0
Reablement at home	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation at home	139	139	139	139	139	139	139	139	139	139	139	139
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	41	41	41	41	41	41	41	41	41	41	41	41
Other short-term social care	19	19	19	19	19	19	19	19	19	19	19	19

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.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement at Home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation at home	Monthly capacity. Number of new clients.	705	736	766	797	827	858	858	858	858	858	858	858
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	161	161	161	161	161	161	161	161	161	161	161	161

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
60%	40%	
60%	40%	
60%	40%	
90%	90%	
90%	90%	

Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	74	74	74	74	74	74	74	74	74	74	74	74	50%	50%	

3.4 Capacity - Community

	Capacity - Community													Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	150	150	150	150	150	150	150	150	150	150	150	150			
Urgent Community Response	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	60%	40%	
Reablement at Home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	60%	40%	
Rehabilitation at home	Monthly capacity. Number of new clients.	139	139	139	139	139	139	139	139	139	139	139	139	60%	40%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	90%	90%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	41	41	41	41	41	41	41	41	41	41	41	41	90%	90%	
Other short-term social care	Monthly capacity. Number of new clients.	19	19	19	19	19	19	19	19	19	19	19	19	50%	50%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Nottinghamshire

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Nottinghamshire	£7,886,632	£7,886,632
DFG breakdown for two-tier areas only (where applicable)		
Ashfield		
Bassetlaw		
Broxtowe		
Gedling		
Mansfield		
Newark and Sherwood		
Rushcliffe		
Total Minimum LA Contribution (exc iBCF)	**£7,886,632**	**£7,886,632**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Nottinghamshire	£4,334,983	£4,334,983

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Nottingham and Nottinghamshire ICB	£3,778,085	£3,778,085

Total ICB Discharge Fund Contribution	£3,778,085	£3,778,085

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Nottinghamshire	£30,920,338	£30,920,338
Total iBCF Contribution	**£30,920,338**	**£30,920,338**

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

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

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Nottingham and Nottinghamshire ICB	£68,512,792	£72,390,616
Total NHS Minimum Contribution	**£68,512,792**	**£72,390,616**

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

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£68,512,792**	**£72,390,616**	

	2023-24	2024-25
Total BCF Pooled Budget	**£115,432,831**	**£119,310,655**

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Nottinghamshire

<< 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	£7,886,632	£7,886,632	£0	£7,886,632	£7,886,632	£0
Minimum NHS Contribution	£68,512,792	£68,512,792	£0	£72,390,616	£72,390,616	£0
iBCF	£30,920,338	£30,920,338	£0	£30,920,338	£30,920,338	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£4,334,983	£4,334,983	£0	£4,334,983	£4,334,983	£0
ICB Discharge Funding	£3,778,085	£3,778,085		£3,778,085	£3,778,085	£0
Total	**£115,432,831**	**£115,432,830**	**£1**	**£119,310,655**	**£119,310,654**	**£1**

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	£19,469,393	£39,114,008	£0	£20,571,361	£41,327,861	£0
Adult Social Care services spend from the minimum ICB allocations	£26,596,932	£26,596,932	£0	£28,102,319	£28,102,319	£0

Checklist

Column complete:

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

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109

										Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Short term rehab at care at Home (was ID 1 7 day	NHT lots #10 South Notts. Short term rehab to deliver home first approach	Personalised Care at Home	Mental health /wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
2	Community Beds (was ID 2 'Delayed transfers of Care'	NHT Lot 8 South (lings Bar), plus Fernwood mid Notts	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		1008	1008	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
3	Care Coordination (was ID 2 Delayed transfers of care	Care Navigation Mid Notts - care coordination and MDT working. NHT Intermediate	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
4	Primary Care Enhanced Delivery Services (was ID 3	GP Enhanced Delivery Scheme - supporting coordination and MDT risk assessment of	Prevention / Early Intervention	Risk Stratification					Primary Care		NHS			NHS	Minimum NHS Contribution
5	Care Coordination (was ID 3 reducing non-elective	South Notts NHT Integrated Care Team - antipatory care model, MDT, care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
6	? Crisis response (was ID 3 reducing non-elective and	British Red Cross Crisis. Query separate Call for Care and Bassetlaw	Urgent Community Response	Reablement at home (to prevent admission to hospital or residential care)					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
7	Crisis Repsonse (was ID 3 reducing non-elective	South Notts NHT Integrated Care Team- 2hr urgent repsonse	Urgent Community Response	Reablement at home (to prevent admission to hospital or residential care)					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
8	Care Coordination	NHT Mid Notts Community Nursing Service inc. care cooridination, case	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
9	Falls Prevention (was schemed ID 3 reducing non-	NHT Mid Notts Community Rehab Falls	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
10	Falls Prevention (was schemed ID 3 reducing non-	Community Falls Rehab- East Bridgford Fracture Liaison Service	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
11	Evening and night nursing	NHT lot 4 Evening and Night Service plus Mid Notts Night Nursing	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12	Carers Short Breaks (was sheme ID 4 Carers	Carers 'NHS' Short Breaks Note schemed ID 7 also Carers - dementia- can we	Carers Services	Respite services		403	403	Beneficiaries	Other	Carers	NHS			NHS	Minimum NHS Contribution
13	ED front door and streaming (was ID 6 Mid Notts	ED Streaming in SFHT block contract	Integrated Care Planning and Navigation	Care navigation and planning					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution
14	Bassetlaw Neighbourhood Teams (was ID9)	Bassetlaw Neighbourhood Teams (was ID9)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	Minimum NHS Contribution
15	Bassetlaw MH Liaison (was ID10)	Bassetlaw MH Liaison (was ID10)	Integrated Care Planning and Navigation	Care navigation and planning					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
16	Bassetlaw Dischage & Assesment (was	Bassetlaw Dischage & Assesment (was ID11	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
17	Bassetlaw Dischage & Assesment (was	Bassetlaw Dischage & Assesment (was ID11	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Mental Health		NHS			NHS Mental Health Provider	Minimum NHS Contribution
18	Bassetlaw Dischage & Assesment (was	Bassetlaw Dischage & Assesment (was ID11	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Acute		NHS			NHS Acute Provider	Minimum NHS Contribution

19	Bassetlaw Respite (was ID12)	Bassetlaw Respite (was ID12)	Care Act Implementation Related Duties	Other					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
20	Bassetlaw Care Home Quality (was ID13)	Bassetlaw Care Home Quality (was ID13)	Other	Care home					Community Health		NHS			Private Sector	Minimum NHS Contribution
21	O. Support for carers	Carer Advice and Support	Carers Services	Carer advice and support related to Care Act duties		5855	7449	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
22	P. Protecting social care	Supporting People	Prevention / Early Intervention	Other	Supporting People				Social Care		LA			Local Authority	Minimum NHS Contribution
23	P. Protecting social care	Nursing & Dementia beds, demand for interim placments	Residential Placements	Nursing home		80	80	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
24	P. Protecting social care	Supported accomodation for younger adults	Residential Placements	Supported housing		160	160	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
25	P. Protecting social care	Direct Payments for older and younger adults	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	Minimum NHS Contribution
26	R. Enabling Care Act statutory responsibilities	Enabling Care Act Statutory Responsibilities	Care Act Implementation Related Duties	Other	Enabling Care Act				Social Care		LA			Local Authority	Minimum NHS Contribution
27	Q. Disabled Facilities Grant	Housing	DFG Related Schemes	Other	Housing	520	520	Number of adaptations funded/people	Other	Housing	LA			Local Authority	DFG
28	S. Improved Better Care Fund	Improved Better Care Fund - Meeting Adult Social Care Needs	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	iBCF
29	S. Improved Better Care Fund	Improved Better Care Fund - Reducing pressure on NHS	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
30	S. Improved Better Care Fund	Improved Better Care Fund - Stabilising the social care provider market	Personalised Budgeting and Commissioning						Social Care		LA			Local Authority	iBCF
31	S. Improved Better Care Fund	Improved Better Care Fund - Hospital discharge and 7 day working	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Social Care		LA			Local Authority	iBCF
32	S. Improved Better Care Fund	Improved Better Care Fund - Expansion of reablement	Prevention / Early Intervention	Other	Short Term Services				Social Care		LA			Local Authority	iBCF
33	S. Improved Better Care Fund	Improved Better Care Fund - Meeting Adult Social Care Needs, investment into	Prevention / Early Intervention	Other	Independence Support				Social Care		LA			Local Authority	iBCF
34	P1 Discharge Programme	P1 Discharge Programme	Home-based intermediate care services	Reablement at home (to support discharge)		10400	10400	Packages	Community Health		NHS			NHS Community Provider	ICB Discharge Funding
35	Urgent Care Community Response	Urgent Care Community Response	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
36	Reduced delayed Hospital Discharges and	Additional staffing for Mid Notts and North Notts D2A teams for therapy led Care to	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Local Authority Discharge
36	Reduced delayed Hospital Discharges and	Increased numbers of people supported home from hospital at weekends	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Social Care		LA			Local Authority	Local Authority Discharge
36	Reduced delayed Hospital Discharges and	Additional Ageing Well staffing capacity for reviews	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge

36	Reduced delayed Hospital Discharges and	Social Workers for Joint funded Mental Health Act and NHS Continuing Healthcare	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
36	Reduced delayed Hospital Discharges and	Hospital Discharge Strategic Commissioner	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
36	Reduced delayed Hospital Discharges and	LW Strength Based Approaches and Mental Health Reforms	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
36	Reduced delayed Hospital Discharges and	Increased Social Work capacity for social supervision (Mental Health)	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
36	Reduced delayed Hospital Discharges and	Mental Capacity Act Practice Lead	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
37	Planning Services in advance and enabling providers	Extended Connect Plus voluntary sector capacity for people who need a small	Enablers for Integration	Voluntary Sector Business Development					Social Care		LA			Local Authority	Local Authority Discharge
37	Planning Services in advance and enabling providers	Additional capacity in Voluntary Sector	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	Local Authority Discharge
37	Planning Services in advance and enabling providers	Bespoke landing page so public can see vacancies in care sector; deep dive into	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
38	Learning from the evaluation of the impact of previous	Mental health step down/up beds	Residential Placements	Supported housing		52	24	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge
38	Learning from the evaluation of the impact of previous	Surge (Homecare provision) and bed capacity	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		23729	9759	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge
39	Improving collaboration and information	MH Hospital Discharge Commissioner	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
39	Improving collaboration and information	ICP Strategic System Transformation Partners x2 to align with ICB System	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
39	Improving collaboration and information	Development of integrated therapy training: Occupational Therapist and Project	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge
39	Improving collaboration and information	Develop more integrated working across community health and social care	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'

5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

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

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Nottinghamshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	203.3	183.5	196.7	184.0	Avoidable admissions plan has been set on a smallish reduction on the quarterly actuals for 2022 23 (neither LA achieved the 2022 23 plans set last year). Both LA's benchmark well against their peer LA's for the avoidable admissions metric.	We are piloting primary care led MDTs across 5 PCN sites to test and develop our approach to ensuring that frail older people receive the right care at the right time in the right place. Pilots to be evaluated to understand early indicators of success to inform the priority areas for 2023/24.
	Number of Admissions	1,991	1,797	1,926	-		
	Population	828,224	828,224	828,224	828,224		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	201.3	181.7	194.7	192.6		

>> 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	2,068.9	1,887.0	1,887.0	Plan for 2023 24 has been set at a maintenance of the 2022 23 position as you can see there was a marked decrease in the number of falls / rate when compared to 2021 22. Urgent Care Response and Community First Responder Services in place and all EMAS conveyances to hospital from Care Homes	In Nottingham and Nottinghamshire, Urgent Community Response (UCR) providers respond to both level one and level two falls (as per the Association of Ambulance Chief Executives definition). Moving forwards, the ambition it to expand upon the direct referrals into UCR from Care Homes as well as Technology
	Count	3,640	3320	3320		
	Population	176,230	176230	176230		

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	Quarter (%)	91.0%	90.9%	90.9%	94.0%	Nottinghamshire finished in the lower half of their peer froup for 2022/23 discharges and below the England average. Applied an ambitious stretch of 94% by Q4 2023/24 of discharges to usual place of residence to improve on current postion and align with target set for Nottingham City, stepping up from current positon per quarter.	During 2023-24 we will continue to invest in and transform our P1 offer and are working towards integrating health and social care teams to provide the support patients need at home after hospital discharge. This will improve patient outcomes by reducing time spent in hospital, providing earlier reablement and rehabilitation to maximise functional outcome and reduce demand on long-term
	Numerator	16,090	16,009	16,305	16,431		
	Denominator	17,681	17,615	17,941	17,480		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	92.0%	92.5%	93.0%	94.0%		
	Numerator	17,272	17,658	16,795	16,595		
	Denominator	18,774	19,089	18,060	17,655		

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	576.9	523.8	573.9	532.5	This target would represent a 3% reduction in LTC numbers in residential and nursing which is in line with East Midlands neighbours	This work sits within our AW Strength Based Approaches programme, which has 3 main elements: Improving practice and culture to more personalised, strength-based approaches · Working with partners on practice, policy and processes e.g.
	Numerator	1,010	952	1,043	985		
	Denominator	175,086	181,738	181,738	184,985		

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 (%)	85.5%	85.0%	83.7%	85.0%	Achievement of this target will show significant improvement on the previous year. It is an ambitious target in terms of activity and the percentage is set above the latest available national average.	Changes to the operational management of the internal MIS reablement team will increase capacity and there is a planned expansion of the service.
	Numerator	431	714	513	714		
	Denominator	504	840	613	840		

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan

NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

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