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Health and Wellbeing Board
Tuesday, 26 September 2023, 2.00 pm, Wyre Forest District Council Offices, Finepoint Way Kidderminster

Membership

Councillors:

Cllr Karen May (Chairman), Dr Sarah Raistrick (Vice Chairman), Simon Adams, Vic Allison, Cllr Christopher Day, Cllr Lynn Denham, Sarah Dugan, Mark Fitton, Cllr Ian Hardiman, Cllr Adrian Hardman, Cllr Lucy Harrison, Supt Rebecca Love, Cllr Steve Mackay, Lisa McNally, David Mehaffey, Jo Newton, Chris Roberts, Tina Russell, Simon Trickett, Cllr Shirley Webb, Dr Jonathan Wells, Cllr Christine Wild and Gary Woodman

Agenda Supplement

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Agenda produced and published by the Assistant Director for Legal and Governance, County Hall, Spetchley Road, Worcester WR5 2NP. To obtain further information or hard copies of this agenda, please contact Kate Griffiths KGriffiths@Worcestershire.Gov.uk

All the above reports and supporting information can be accessed via the Council's website here

Date of Issue: Monday 18 September 2023

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BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

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

5. Income

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

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

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

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

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

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

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

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

6. Expenditure

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

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

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

On this sheet please enter the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Metrics

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

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

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

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

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

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

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

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

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

8. Planning Requirements

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

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

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

		Complete:
Health and Wellbeing Board:	Worcestershire	Yes
Completed by:	Victoria Whitehouse	Yes
E-mail:	vwhitehouse@worcestershire.gov.uk	Yes
Contact number:	01905 643574	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	Karen	May	KMay@worcestershire.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Simon	Trickett	simon.trickett@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Mark	Dutton	mark.dutton@nhs.net	Yes
	Local Authority Chief Executive		Paul	Robinson	PRobinson@worcestershire.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Mark	Fitton	MFitton@worcestershire.gov.uk	Yes
	Better Care Fund Lead Official		Victoria	Whitehouse	vwhitehouse@worcestershire.gov.uk	Yes
	LA Section 151 Officer		Steph	Simcox	SSimcox@worcestershire.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 -->

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Worcestershire

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£6,163,577	£6,163,577	£6,163,577	£6,163,577	£0
Minimum NHS Contribution	£46,773,733	£49,421,127	£46,773,733	£49,421,127	£0
iBCF	£19,024,460	£19,024,460	£19,024,460	£19,024,460	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£2,667,200	£4,427,552	£2,667,200	£4,427,552	£0
ICB Discharge Funding	£2,095,333	£4,444,667	£2,095,333	£4,444,667	£0
Total	**£76,724,303**	**£83,481,383**	**£76,724,303**	**£83,481,383**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£13,291,768	£14,044,082
Planned spend	£29,276,935	£30,243,076

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£15,949,018	£16,851,732
Planned spend	£17,496,798	£19,178,051

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)	156.9	148.4	169.2	156.5

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	1,570.7	1,466.6
	Count	2242	2129
	Population	142738	145221

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)	90.9%	90.9%	90.7%	90.4%

Residential Admissions

	2021-22 Actual	2023-24 Plan

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	585	535

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 (%)	83.0%

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: Worcestershire

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.	Adult Discharges are emergency and Elective G&A, excludes SDEC at WAT - not able to exclude SDEC at other providers so pathway 0 Other may be over reported. For pathway 1 Capacity per month is is based on 130 discharges from Acute, Community and Out of Area hospitals into Pathway 1 services. Capacity available is affected by staffing availability (i.e. staff vacancies) and skills requirements for referrals (i.e. a requirement for Neighbourhood Team input). Actual activity is affected by staff availability, skills required for the referral, the complexity of the referral, the size of the package of support required, failed discharges (where capacity is planned but subsequently not used) and receiving

	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!!

(Select as many as you need)

Demand - Hospital Discharge

Trust Referral Source	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
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Social support (including VCS) (pathway 0)	2104	2213	2179	2180	2239	2322	2355	2266	2242	2198	2077	2199
OTHER		733	780	808	808	750	782	957	882	790	796	762	790
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Reablement at home (pathway 1)	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
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Rehabilitation at home (pathway 1)	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
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Short term domiciliary care (pathway 1)	214	242	252	244	255	251	325	289	287	316	269	312
OTHER		138	166	169	142	196	138	100	153	138	142	141	143
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Reablement in a bedded setting (pathway 2)	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
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	204	216	198	218	217	186	175	205	179	196	183	209
OTHER		31	36	40	38	29	33	24	30	38	30	21	31
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	2	10	6	1	7	10	4	13	7	15	12	11
OTHER	(pathway 3)	15	17	17	12	4	1	1	2	5	20	15	9

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	1192	1192	1192	1202	1202	1202	1202	1202	1202	1192	1192	1192
Reablement at home	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation at home	80	80	80	80	80	80	80	80	80	80	80	80
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	233	241	221	231	229	194	195	221	208	231	196	226
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.	3138	3275	3168	3203	3320	3168	3340	3189	3248	3275	2948	3278
Reablement at Home	Monthly capacity. Number of new clients.	557	575	557	575	575	575	575	557	575	575	539	575
Rehabilitation at home	Monthly capacity. Number of new clients.	40	40	40	40	40	40	40	40	40	40	40	40
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.	230	240	232	238	240	231	239	232	238	240	224	238
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	40	40	40	40	40	40	40	40	40	40	40	40

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

ICB	LA	Joint

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	Monthly capacity. Number of new clients.	1192	1192	1192	1202	1202	1202	1202	1202	1202	1192	1192	1192
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.	80	80	80	80	80	80	80	80	80	80	80	80
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

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

ICB	LA	Joint

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Worcestershire

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Worcestershire	£6,163,577	£6,163,577	Yes
DFG breakdown for two-tier areas only (where applicable)			
Bromsgrove	£1,036,273	£1,036,273	
Malvern Hills	£682,875	£682,875	
Redditch	£952,377	£952,377	
Worcester	£780,221	£780,221	
Wychavon	£1,251,934	£1,251,934	
Wyre Forest	£1,459,897	£1,459,897	
Total Minimum LA Contribution (exc iBCF)	**£6,163,577**	**£6,163,577**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Worcestershire	£2,667,200	£4,427,552	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Herefordshire and Worcestershire ICB	£2,095,333	£4,444,667	Yes
Total ICB Discharge Fund Contribution	£2,095,333	£4,444,667	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Worcestershire	£19,024,460	£19,024,460	Yes
Total iBCF Contribution	**£19,024,460**	**£19,024,460**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No	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	
				Yes
Total Additional Local Authority Contribution	**£0**	**£0**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
	£46,773,733	£49,421,127
Total NHS Minimum Contribution	**£46,773,733**	**£49,421,127**

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	
				Yes
Total Additional NHS Contribution	**£0**	**£0**		
Total NHS Contribution	**£46,773,733**	**£49,421,127**		

	2023-24	2024-25
Total BCF Pooled Budget	**£76,724,303**	**£83,481,383**

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: Worcestershire

<< Link to summary sheet

	2023-24			2024-25		
Running Balances	Income	Expenditure	Balance	Income	Expenditure	Balance
DFG	£6,163,577	£6,163,577	£0	£6,163,577	£6,163,577	£0
Minimum NHS Contribution	£46,773,733	£46,773,733	£0	£49,421,127	£49,421,127	£0
iBCF	£19,024,460	£19,024,460	£0	£19,024,460	£19,024,460	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£2,667,200	£2,667,200	£0	£4,427,552	£4,427,552	£0
ICB Discharge Funding	£2,095,333	£2,095,333		£4,444,667	£4,444,667	£0
Total	**£76,724,303**	**£76,724,303**	**£0**	**£83,481,383**	**£83,481,383**	**£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			2024-25		
	Minimum Required Spend	Planned Spend	Under Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£13,291,768	£29,276,935	£0	£14,044,082	£30,243,076	£0
Adult Social Care services spend from the minimum ICB allocations	£15,949,018	£17,496,798	£0	£16,851,732	£19,178,051	£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):
60, 61,

										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	General Rehab Beds	Intermediate Care Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		1704	1760	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£13,216,339	£13,652,479	58%
2	Intermediate Beds	Intermediate Care Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		246	254	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,910,814	£1,973,871	100%
3	Neighbourhood Teams	Neighbourhood Teams bring together a range of professionals, including	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£8,080,931	£8,347,602	32%
4	Onward Care Team	OCT is an integrated health and social care service that in-reaches into Worcester Acute	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£737,716	£762,061	76%
5	Worcestershire IP Unit - Pathway 2	Intermediate Care Beds - D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		456	471	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£5,331,135	£5,507,063	100%
6	Pathway 1 (UPI)	P1 supports individuals to return home with support following a stay in hospital,	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		5541	5541	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£7,162,446	£8,551,339	87%
7	Pathway 1 (UPI)	P1 supports individuals to return home with support following a stay in hospital,	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		803	803	Packages	Social Care		LA			Local Authority	iBCF	Existing	£1,038,224	£1,038,224	13%
8	Rapid Response Social Work Team	Provide out of hours / enhanced duty social work to provide a rapid response from	Urgent Community Response						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£385,683	£397,253	99%
9	Rapid Response Social Work Team	Provide out of hours / enhanced duty social work to provide a rapid response from	Urgent Community Response						Social Care		LA			Local Authority	iBCF	Existing	£1,263	£1,263	1%
10	Pathway 1+	P1 + supports individuals to return home with wraparound support	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)		35040	52560	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£279,359	£463,663	100%
11	Pathway 3 (SPOT DTA)	Provision of Pathway 3 (DTA) service in care homes	Residential Placements	Short term residential care (without rehabilitation or reablement input)		53	53	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£229,571	£229,571	34%
12	Pathway 3 (SPOT DTA)	Provision of Pathway 3 (DTA) service in care homes	Residential Placements	Short term residential care (without rehabilitation or reablement input)		103	103	Number of beds/Placements	Social Care		LA			Private Sector	iBCF	Existing	£440,218	£440,218	66%
13	ASWC in Community Hospitals,	Contributes towards costs of Hospital Teams who assist in Faciliating DTA's	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	£510,286	£525,595	45%
14	ASWC in Community Hospitals,	Contributes towards costs of Hospital Teams who assist in Faciliating DTA's	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	iBCF	Existing	£504,000	£504,000	44%

15	Carers	Commissioned service responsible for, Short term support to enable people to	Carers Services	Respite services		244	244	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,158,022	£1,158,022	14%
16	Carers	Commissioned service responsible for, Short term support to enable people to	Carers Services	Respite services		21	21	Beneficiaries	Social Care		LA			Local Authority	iBCF	Existing	£101,978	£101,978	1%
17	Implementation of the Care Act- Additional demand	Contribution towards the increased demand for services following the	Home Care or Domiciliary Care	Other	Provision of Homecare	102158	105222	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,278,115	£2,346,458	8%
18	Implementation of the Care Act- Additional demand	Contribution towards the increased demand for services following the	Home Care or Domiciliary Care	Other	Provision of Homecare	13405	13405	Hours of care	Social Care		LA			Private Sector	iBCF	Existing	£298,942	£298,942	1%
19	Complex Cases	Contribution towards the cost of S117 eligible clients	Residential Placements	Other	Funding Specific S117 Clients	15	15	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£803,500	£803,500	3%
20	WCES	Loan of equipment to Worcestershire residents / those registered with a	Assistive Technologies and Equipment	Community based equipment		16170	16170	Number of beneficiaries	Social Care		LA			NHS Community Provider	Minimum NHS Contribution	Existing	£1,762,000	£1,762,000	46%
21	Disabled Facilities Grant	Disabled Facilities Grant passported to District Councils to spend on their	DFG Related Schemes	Adaptations, including statutory DFG grants		570	570	Number of adaptations funded/people	Other	Housing Related	LA			Local Authority	DFG	Existing	£5,663,577	£5,813,577	92%
22	Disabled Facilities Grant	Disabled Facilities Grant passported to District Councils to spend on their	DFG Related Schemes	Discretionary use of DFG		500	430	Number of adaptations funded/people	Other	Housing Related	LA			Local Authority	DFG	Existing	£500,000	£350,000	8%
23	Social Work Alignment to GP Sugeries	Social Workers supporting Neighbourhood teams responsible to urgent needs	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£322,816	£332,500	100%
24	Investment in Care Homes	Contribution towards increase in demand	Residential Placements	Care home		62	62	Number of beds/Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,500,000	£2,500,000	9%
25	BCF Homelessness Post	Contribution towards support of Homelessness in Hospital Pathway Team	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution	New	£53,000	£54,590	100%
26	BCF Support	Funding of BCF Commissioning Manager Post	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution	New	£52,000	£53,560	100%
27	iBCF Mitigating Social Care Pressures	Expenditure covers a mixture of Homecare, Residential and preventative schemes	Care Act Implementation Related Duties	Other	Expenditure covers a mixture of homecare and				Social Care		LA			Private Sector	iBCF	Existing	£15,639,835	£15,639,835	94%
28	iBCF supporting pressures on the NHS	iBCF supporting pressures on the NHS	Community Based Schemes	Other	Supporting Pressures on the NHS				Community Health		NHS			NHS	iBCF	Existing	£1,000,000	£1,000,000	6%
29	Pathway 1 (UPI)	P1 supports individuals to return home with support following a stay in hospital,	Home Care or Domiciliary Care	Domiciliary care packages		6836	11348	Hours of care	Social Care		LA			Local Authority	Local Authority Discharge	New	£930,246	£1,544,209	11%
30	Pathway 1 (UPI)	P1 supports individuals to return home with support following a stay in hospital,	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		528	876	Packages	Social Care		LA			Local Authority	Local Authority Discharge	New	£497,938	£826,577	6%
31	Pathway 2 Care Services	Intermediate Care Beds - D2A Pathway	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		15	15	Number of Placements	Community Health		LA			Local Authority	Local Authority Discharge	New	£14,391	£23,890	1%
32	Pathway 3 (SPOT DTA)	Provision of Pathway 3 (DTA) service in care homes	Residential Placements	Short term residential care (without rehabilitation or reablement input)		106	176	Number of beds/Placements	Social Care		LA			Local Authority	Local Authority Discharge	New	£1,218,991	£2,023,525	100%
33	WCES	Loan of equipment to Worcestershire residents / those registered with a	Assistive Technologies and Equipment	Community based equipment		144	239	Number of beneficiaries	Social Care		LA			Local Authority	Local Authority Discharge	New	£5,634	£9,351	1%
34	Pathway 2 Discharge Beds	Intermediate Care Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		43	44	Number of Placements	Community Health		NHS			Local Authority	ICB Discharge Funding	New	£500,000	£516,500	100%
35	Pathway 2 Rehab Beds	Intermediate Care Unit	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		57	59	Number of Placements	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£899,000	£928,667	100%
36	Support for Hospital Discharge	Pathway Transition	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£696,333	£719,312	17%
37	Pathway 1 - Community Support incl	Scheme to enable discharge from hospital is timely and effective	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£0	£2,280,188	0%

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: Worcestershire

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	161.0	149.6	174.7	144.9	23-24 modelled on historic activity	Delivery of schemes associated within our pre-hospital workstream which is part of our home first committee.	Yes
	Number of Admissions	1,211	1,125	1,314	-			
	Population	595,786	595,786	595,786	595,786			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	156.9	148.4	169.2	156.5			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	1,689.6	1,570.7	1,466.6	5% reduction in admissions per year	Delivery of schemes associated within our pre-hospital workstream which is part of our home first committee.	Yes
	Count	2,360	2242	2129			Yes
	Population	138,949	142738	145221			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 (%)	90.4%	90.6%	90.3%	89.8%	23-24 modelled on historic activity	Delivery of agreed recommendations in the Long LOS and Flow Report.	Yes
	Numerator	10,054	10,439	10,123	9,387			
	Denominator	11,123	11,521	11,216	10,448			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	90.9%	90.9%	90.7%	90.4%			

	Numerator	10,601	10,743	10,656	10,173			Yes
	Denominator	11,665	11,812	11,743	11,258			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	585.0	592.0	518.4	535.0	Please note numerator is correct but rate is calculated here using a different population figure to ASCOF definition so rates will vary. Target set based on a 5% estimated increased around demand pressures -	Extensive scrutiny of all placements in long term care; all alternative provision considered as first option	Yes
	Numerator	804	845	740	777			Yes
	Denominator	137,439	142,738	142,738	145,221			

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 (%)	80.8%	82.0%	83.6%	83.0%	Target has been set based on 2022-23 performance. Given the challenge of increasing complexity of need anything higher is not deemed to be achievable	Concentrated efforts to ensure reablement needs prioritised	Yes
	Numerator	497	504	622	618			Yes
	Denominator	615	615	744	745			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: Worcestershire

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

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

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	Narrative Plan Expenditure Plan			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	Narrative Plan Expenditure Plan			Yes

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NHS
Herefordshire
and Worcestershire

worcestershire
countycouncil

Cover

Health and Wellbeing Board

Worcestershire Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan.

Ongoing discussions and system wide meetings have enabled a range of key stakeholders to be involved in the preparation and review of proposals that sit within the BCF 2023/2025 plan. Information and data are shared across the system to inform the BCF planning to consider how organisations and providers are meeting the BCF outcomes and metrics. Stakeholders include but are not limited to Worcestershire County Council (WCC), Herefordshire & Worcestershire Health & Care Trust, NHS Herefordshire & Worcestershire ICB, Primary Care Networks, Worcestershire Healthwatch, voluntary and community organisations, Worcestershire Association of Carers, members of the Worcestershire Strategic Housing Officers Group. Engagement and involvement has been through a variety of system wide and internal meetings, including the Integrated Commissioning Executive Officers Group (ICEOG) as part of developing the Integrated Care System in Herefordshire and Worcestershire. WCC has recently developed and launched their Building Together policy, this supports co-production to ensure thoughts, ideas and suggestions of people who use services are utilised to develop and shape provision. Prior to this, services supported by the BCF have always sought to involve people who use services and worked in a collaborative way in addition to working with key partners such as Health Watch. There are some groups which are more difficult to engage with such as people who are homeless or rough sleepers due to the transient nature of their accommodation and potential needs therefore, it is imperative that services are measured by outcomes. The homeless in hospital pathway for example, is developing an outcomes framework to evaluate the effectiveness of the service, involvement and engagement will be undertaken by liaising directly with people who have used the service but also through links with partner organisations such as St.Paul's hostel and District housing authorities. Other services supported by BCF, for example the reablement service, collates user experience and outcome at the end of each intervention to inform and shape the service as it evolves. Worcestershire's BCF 2023-2025 plans have been shared with the ICB Executive Leadership Team and Strategic Commissioning Committee. The plans have been jointly agreed at ICEOG and circulated to Worcestershire Health and Wellbeing Board for virtual sign off ahead of formal ratification at the next board meeting in September 2023.

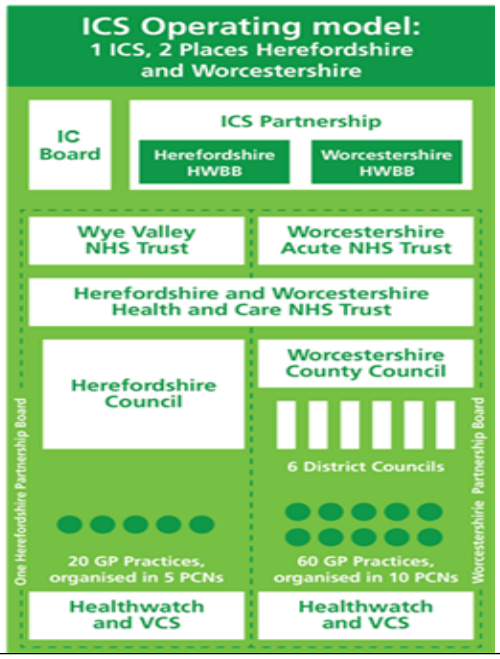
Governance

The Worcestershire Health and Wellbeing Board is responsible for agreeing the Better Care Fund plans and for overseeing delivery through quarterly financial monitoring reports. Oversight and responsibility for the Better Care Fund is embedded within the Senior Leadership Teams of both the People Directorate within WCC and NHS Herefordshire and Worcestershire ICB. In each organisation, this is led by Chief Officers, who can maintain the profile of the shared agendas and ensure linkages to wider health and social care commissioning and delivery.

The senior leaders of the two organisations formed the Integrated Commissioning Executive Officers Group (ICEOG) in Worcestershire. ICEOG meet monthly and its aim is to progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents. This will be achieved through:

- The development of strategies that support the integration of care across adults and children's services – in the context of the Integrated Care System, Joint Strategic Needs Assessment, Joint Health and Well-being Strategy, the Children and Young People's Plan and other relevant strategic plans across the Council and the Integrated Care Board (ICB)
- Ensuring effectiveness, safety and improved experience of services commissioned under the Section 75 (S75) agreement.
- Supporting the development of new models of care, focussing specifically upon integration and improvement of health and social care, and ensuring synergy with the place-based governance through Worcestershire Executive Committee.

ICEOG provides reports of the progress and ambitions for integration priorities within Worcestershire to the Health & Wellbeing Board. The governance arrangements continue to support collaborative working between health and social care services to increase joint working and alignment of commissioning arrangements. The group seeks to develop and implement appropriate and effective integrated commissioning plans in accordance with the priorities, outcomes and budgets set by the respective governing bodies and the Health and Well-being Board.



Executive Summary

- *Priorities for 2023-2025*
- *Key changes since previous BCF plan*

Key System Priorities and ambitions for 2023- 2025:

- Hospital Discharge and Flow
- Care Market Development
- Management of Social Care Demand
- Intermediate Care

1. To agree an extension to the pilot integrated intermediate care service in 2023/2025, with a view to finalising the operating model and specifications of the service with all system partners as the 2-year pilot draws to a close in quarter 3 2023/2024.

2. Some changes to capacity within the pathways was required in 2022/3 leading to a decision to undertake more detailed demand and capacity planning for Pathway 1 and Pathway 3 based on learning over the previous 18 months, ahead of winter 2023/2024, to ensure that planned hospital discharges can continue to be supported in a timely manner.

3. Following a 4-month review of the wraparound service pilot, in 2022/2023 it was agreed to extend the pilot from the original 6 months to 18 months with the pilot drawing to a close in quarter 2, 2023/2024. The wrap around care service pilot supports people to return home from hospital with a period of 24/7 wrap around care, enabling a slightly long assessment period prior to determining any future care needs.

4. To review how the Intensive Assessment Rehabilitation Unit (IAR) beds were opened and embedded into the pathway services with the aim of ensuring maximum reablement opportunities for those still requiring use of bed-based care.

5. Partners continued to analyse flow across the system and identify opportunities to deliver integrated approaches where there is benefit to flow and efficiency and support for a home first approach. This has been particularly challenging during the winter months exacerbated by ongoing industrial unrest within the health service.

6. Implementation of a long-term homelessness pathway.

The system priorities are interlinked and rely on each partner to work collaboratively for success throughout the system.

Within the 2021/2022 BCF plan, and throughout 2022/2023, it was highlighted that a significant level of funding had been committed to support the removal of delay and within the D2A pathways. The system continued to focus on these areas:

- Continuation of the council's reablement service (Home-first) and the wraparound care service. This has met the significant levels of demand for Pathway 1, enabling people to be discharged from hospital within 24 hours in line with National Discharge Targets. The emphasis on supporting people to go home and to remain at home should have an impact on reducing admissions to long-term care.

- The onward care team continues to practice a multi-disciplinary approach to identify the correct discharge pathway and care and support plan. This positively impacts length of stay in the acute hospitals and ensure national hospital discharge targets are achieved.

- A review of Pathway 3 to reduce the use of care home provision through the Intensive Assessment and Rehabilitation (IAR) Unit.

- The Integrated Intermediate Care Service which facilitates effective partnership working and the ability to analyse flow across the system was extended until September 2023. This will identify opportunities to integrate services where there are benefits to flow and efficiency, following a short-term model of delivery and allow for a longer-term view on the service and its future operation to be taken.

Key changes since the previous BCF Plan

Overall, the BCF 2023-2025 plan largely remains focussed on the continuation of schemes, services and work force investments that support the two national conditions; providing care in the right place at the right time and enabling people to stay safe well and independent for longer and supporting unpaid carers. Following the successful 18-month pilot of the Pathway 1+ (wrap around) service, the opportunity for further investment is under discussion, with the service potentially increasing capacity to support additional people in the next two years, following the positive impact the service has had over the pilot period. This service supports a timely hospital discharge for people who otherwise may not have been able to return home due to complexity of need and/or requiring intensive care and support for a transitional period and a full assessment carried out at home.

Implementation of the homelessness in hospital pathway is a key change in the 2023-2025 plan. The BCF 2023-2025 plan contributes towards expanding this service to support people who are or become homeless upon access to hospitals in the county due to a multitude of reasons with an integrated approach across health, social care and housing where necessary.

Recruitment has continued to be a local challenge which has had an impact on the entirety of the adult health and social care sector. The recovery and stability of the care market following Covid 19 will continue to have an impact on services funded through the BCF 2023-2025 plan and will be an area of focus. In Worcestershire we have seen some improvement with workforce capacity within domiciliary care, which could be linked to the annual fee review from the local authority. Commissioners continually analyse the local workforce needs and plan with providers how to build sufficient capacity alongside developing the skills, knowledge and values required for the workforce. Through our Independence Focussed Domiciliary Care contracts we are now able to work more closely with a selection of providers to more effectively shape the market and take a whole system approach. Understanding the future demand for services, provides clear information to inform our long-term plans through our Market Position statements (in relation to the size, skills and values of the workforce).

National Condition 1: Overall BCF plan and approach to integration

Approach to embedding integrated, person-centred health, social care and housing services. Changes to the services commissioned through the BCF from 2023- 2025 and how they will support further improvement of outcomes for people with care and support needs.

Worcestershire Health and Wellbeing Board have developed the Health and Wellbeing Strategy 2022-2032. The Joint Health and Wellbeing Strategy focuses on good mental health and wellbeing with a particular steer and focus on prevention and tackling health inequalities to improve health and wellbeing outcomes for Worcestershire's residents. This priority will be supported by:

- Healthy living at all ages
- Safe, thriving and healthy homes, communities and places
- Quality local jobs and opportunities.

Herefordshire & Worcestershire ICS are in the latter stages of developing its ten-year Integrated Care Strategy in Herefordshire and Worcestershire. The strategy utilises the Joint Strategic Needs Assessment that identifies the key shared priorities for improvement of outcomes for the local people.

- Providing the best start in life
- Living and ageing well
- Reducing ill health and premature deaths from avoidable causes

The two strategies are aligned and instil a shared approach to delivering better outcomes for local people. Worcestershire's Better Care Fund 2023-2025 plan continues to promote integration between health, social care and housing within Worcestershire and in support of the priorities outlined within the system-wide and place-based strategies. The schemes and services jointly commissioned through the BCF continue to develop partnership working and integration to support people with care needs, ensuring residents receive care in the right place at the right time and remain independent at home for longer. Also, to continue support unpaid carers in line with the Worcestershire All Age Carers Strategy.

Joint priorities for 2023-2025 include: -

- Reviewing the performance of the extended Integrated Intermediate Care Service pilot against need and determining the longer-term operational structure and operational service requirement to ensure a seamless approach to admission avoidance and prevention

- An integrated homelessness pathway for individuals admitted to hospital

- An integrated mental health offer for residents in Worcestershire

During 2023-2025, work will continue across the wider health and care system to develop the Intermediate Care Framework. The Framework describes how we will support people after a hospital admission or a crisis event in the community (including rehabilitation, reablement and recovery) including the Core20PLUS target population cohort; therefore, it will support both hospital discharge and admission avoidance services. Whilst there are good intermediate care services across Worcestershire, there is room for improvement specifically how we integrate and work more collaboratively regarding hospital avoidance and prevention services, this will result in a seamless approach for our residents and enable us to work more closely to provide the right care at the right time. The key aims we aspire to (in line with the proposed national framework) are:

1. Person-centred and in partnership with carers
2. Home based by default
3. Therapy led
4. 7 days a week
5. Integrated across health and social care – jointly commissioned, based on population needs
6. Includes those at end of life and those with cognitive impairment
7. Truly multi-disciplinary – joint workforce planning
8. Outcomes driven – services focussed on continual improvement through use of local data intelligence
9. Reduces workload for primary care
10. One size does not fit all – local innovation encouraged

The collaborative integration approach is evidenced through several services or initiatives, which include, but are not limited to the services below.

Virtual wards

The system is continuing to develop its approach to virtual wards, which is now as part of the National Virtual Wards Programme. The system continues to develop the relationships between NHS providers, including primary care, secondary care, and social care. Scoping is currently taking place in Worcestershire for the implementation of virtual wards for Frailty, COPD, and Heart Failure.

Flow and Discharge dashboard

The system wide flow and discharge dashboard for Worcestershire is embedded and working well, providing one data set that also measures performance and identifies areas for improvement, including the use of SHREWD and the Patient Tracker. This supports targeted intervention at pace, both on an operational basis and through tactical review to adjust resource distribution across the pathways.
Key to the successful delivery of the 2023-2025 plan are health and social care initiatives to support admission avoidance and timely, well-planned discharge, including via the 2-hour response service and in the discharge pathways, aiming to provide sufficient support in the community to enable people to remain independent in their own homes for longer, thereby reducing hospital (re-) admissions and supporting hospital flow.

National Condition 2: BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Approach for integrating care to support people to remain independent at home. Including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home.

Worcestershire County Councils (WCC) People Directorate strategy is a single strategy for people and communities, with a clear aim and a focus on outcomes for people. The strategy was developed and co-produced with people, staff and partners to meet need by maximising the use of assets, resources and the workforce. A central theme is to enable people to stay well, safe and independent at home for as long as possible. The Commissioning strategy is aligned to the Adult Social Care strategy and references developing a Person-Centred Approach, Shaping Services and Shaping an Effective Market. These principles will support and promote people's independence. The Commissioning Strategy and Market Position Statement are directly aligned to the Council's Corporate Plan and Joint Strategic Needs Assessment and both will be refreshed during 2023/2024. Collaborative commissioning is already being delivered through initiatives such as SEND (SEND Strategy), Carers (Commitment to Carers and Carers Strategy) and Assistive Technology (Falls Technology).

The health and care system across Worcestershire will continue to develop an Asset-based community development (ABCD) approach recognising, identifying, and harnessing existing 'assets' wherever possible and will make stronger, system-wide, connections in respect of the population's health management approach.

Public Health within WCC have continued working with the ICS on specific population health management approaches. This includes using population health management approaches to identify and reduce risk in people with pre-diabetes. A local primary care PHM tool has been produced which will help to understand population health and needs within Worcestershire. It is recognised that there is further work to be completed regarding the housing tenure and stock condition data. Currently this data is collected by responsible districts but is not always joined up, accurate or accessible to all partners. Through the work supported by the ICB, datalake is a software being explored to look at an integrated and seamless approach to data collection specifically focussing on housing tenure data and stock condition, this would enable quicker discharge from hospital for those who have a housing need and a more integrated approach for individuals living in the community. The ICB datalake will pool health and social care data from across the ICS and will enable even more population health management approaches going forward.

The BCF in Worcestershire also supports the system to cater for an increase demand for services following the implementation of the Care Act. This contribution includes funding towards domiciliary care to meet Care Act duties and support people to stay well, safe and independent at home for longer. Since the previous BCF 2022/2023 Plan, the Council has identified the provision of a comprehensive high quality domiciliary care service which includes independence focused domiciliary care as fundamental to achieving this. Therefore, the County Council has decided to offer a new contract to domiciliary care providers who are able to deliver a service with a focus on outcomes, maintaining and where possible regaining independence with individuals, as well as to continue domiciliary care where required. This became partly operational in quarter 4 of 2022/2023 and will continue across the length of the BCF 2023-2025 plan.

The Worcestershire Community Equipment Service (WCES) is central to the delivery of the prevention and wellbeing priorities of the ICS and develops its service in line with changing demand in social and health care. WCES provides equipment to support individuals to get home from hospital quickly, rehabilitate once home from hospital, stay home and avoid hospital (re-) admission, increasing function and independence to live well whilst they are at home. WCES delivers the equipment within 24 hours of request to meet an

urgent need and has adapted its working patterns to meet the time demands of discharge to assess and increased reablement activity. Clinical expertise within the service reviews and changes the type of equipment available to prescribers and offers advice, training and support to our clinical prescribing community to ensure best practice of selection and application of community equipment. Clinical experts scrutinise and assure on all requests for non-standard equipment to ensure only essential purchases of specialist items are made and equipment is re-used wherever possible.

Working directly with clinical prescribers, from provider services in health and care across the county at place and neighbourhood level, WCES sources the best value equipment to meet clinical and functional need, considering quality, and re-use/recyclability. This facilitates people with increasingly complex health and care needs to remain at home and be supported at home on discharge, having their equipment needs changed and updated as their conditions progress or changes to ensure the right equipment is in place at the right time to support the right care for the individual.

WCES monitors the reason for equipment need from its clinical prescribers and the discharge pathway the equipment is required for if applicable, evidencing the increased demand for rapid access to specialist equipment to support system flow and get people home with the appropriate support. WCES provide standard equipment to clinical teams at their bases, so it is ready to issue immediately to meet an individual need and have systems to restock and replenish that equipment frequently.

The service continues to see an increase in both client numbers and overall equipment spend. The increase evidences the ongoing focus to provide equipment to enable people to remain in their own homes, to reduce the need for the interventions of domiciliary care, care home placements and avoidable hospital admissions, whilst facilitating hospital discharge. The service continues to see a shift towards urgent need over routine need, and a change in types of equipment requested to more complex and expensive individual items, including increased bariatric equipment. The extent to which urgent need could be reduced by improved and earlier discharge planning may be explored. WCES provide monthly performance (activity) data to its stakeholders to show the number of urgent and routine requests, activity across the discharge pathways including end of life and admission prevention, spend on categories of equipment including data on actual purchase versus use of recycled equipment.

Alongside statutory and local commissioned services, unpaid carers play a key role in enabling people in Worcestershire to stay well, safe and independent at home for longer. The Worcestershire Carers Strategy seeks to place carers at the heart of Worcestershire's families and communities. The strategy includes four outcomes which carers have identified as being important to them:

- Being recognised and valued
- Having a life of my own
- Being supported to maintain my physical and mental wellbeing
- Caring Safely

Worcestershire Association of Carers and YSS have been contracted to support the delivery of this strategy for all carers across Worcestershire and all partners are delivering work which supports Worcestershire's ambition of being a carer friendly county.

WCC also commissions the provision of bed based 'replacement care' (also known as respite care or short breaks) from local care home providers, the objective being, to support a carer to have a break from caring to help them to continue in their caring role and/or to provide care in the event of the carer being unable to continue care provision on an unplanned or emergency basis for example due to their own hospitalisation or illness. Planned Replacement Care provides a short term / temporary placement to give the carer a break

from their caring role, as far as is possible on dates of their choosing e.g., for a family holiday. Emergency Replacement Care provides a short term / temporary placement that is required urgently to cover such eventualities as; risk of the individual remaining in their own home, breakdown of a homecare package, a change in the person's needs or carer breakdown.

Using a categorisation of low, medium and high care needs, placements are made with a range of care homes, including those which have are specialised in providing care for individuals with dementia.
During 2022 (January – December) over 8,700 nights of replacement care for older people were delivered in Worcestershire. This equates to an average of 24 individuals being in receipt of bed-based replacement care every night. The need for bed-based replacement care for older people is expected to remain broadly consistent in 2023/2024 and 2024/2025, although the long-term trend for an increase in placements to support people with dementia is expected to continue.

There are 12 community-based, multi-disciplinary Neighbourhood teams (NTs) within Worcestershire. This service is delivered by Herefordshire and Worcestershire Health and Care NHS Trust. The teams deliver planned care, intermediate care for both hospital admission prevention and supported hospital discharge, urgent community response and end of life care. This is provided 24/7, 365 days of the year with full geographical coverage of Worcestershire. The new frailty virtual wards are also now live and in their "learning phase", delivered via a multi-disciplinary approach.

The NICE reablement guidelines have been adopted and the teams ensure people have person-centred care plans that where appropriate aim to maximise independence and quality of life. This is delivered through therapy-led reablement, rehabilitation and provision of minor equipment and adaptations. Referrals for major adaptations and specialist equipment are made where reablement potential has been exhausted. NTs work in partnership with the Local Authority's Reablement service, to support the delivery of Pathway 1. Also identifying people who would benefit from further reablement with the LA's community reablement service.

Unpaid carers play an essential role in supporting the step-down of NT service provision through supporting the independence and strengths-based approaches. Likewise, timely housing adaptations enable the timely implementation of reablement and step-down of service provision. This is supportive of the proactive and wider hospital admission prevention agenda. Neighbourhood team Leads work closely with the ICB and Primary Care colleagues to develop clinical pathways that support a proactive approach to care. Population health data is utilised to inform service changes and innovations.
Work has started to implement Fuller recommendations through collaborative working with PCN and ICB colleagues. Frailty Virtual wards have provided a good opportunity to integrate the Advanced Clinical Practitioner and Medical Leadership elements of Virtual Wards.

National Condition 2 (cont.) Rationale for the estimates of demand and capacity for intermediate care to support people in the community.

Neighbourhood teams in Worcestershire usually support up to 23 community-based people who no longer meeting the criteria to reside') at any one time across the county. These are broken down to CHC, Social Care and Self-Funding – usually in a 25%, 50% and 25% split respectively. There is consideration for how the increased capacity in the domiciliary care sector and swifter referral pathways could increase capacity within Neighbourhood teams. This could improve patient flow, ensuring that reablement resources are equitably accessible for all who need them. It is understood that rural areas in Worcestershire have higher rates of people who no longer meet the criteria to reside. Therefore, people in these areas may not access reablement services at the earliest opportunities due to the knock-on effect to the available capacity in these localities although the new contracts for home care, once fully operational will greatly improve this situation.

NTs have been working with system partners to improve the step-up process to Community Hospitals to avoid unnecessary acute admissions. Infection control measures can often be a barrier due to patients needing to go into a side room from the community. Ring-fenced beds are currently being explored. In addition, the night sitting service has been aligned with the urgent community response hub to support admission avoidance where possible. Further work is planned with the Local Authority (LA) to consider realigning night services to support a system-wide approach.
The system is confident that the demand and capacity modelling supplied is sufficient for the 2023/2024 period.

Throughout the 2022/2023 period the system participated in the 'National Discharge Challenge'. This series of deep dives within individual systems looked at process, both within acutes settings, community and the functionality of each system's individual 'complex discharge function '. Throughout this period the Worcestershire system consistently performed well and received appropriate feedback from regional colleagues confirming this.

We regular monitor capacity and demand within our intermediate care services and down-stream bedded capacity. We have further growth built into our 'at home 'pathway and within our bedded settings there is some opportunity to generate further capacity by increased utilisation of the 'at-home 'pathway rather than bedded settings.

An independent review of the intermediate care service / bedded capacity has been undertaken, which is managed by our Community Trust via the Onward Care Team and Capacity Management Team. The review highlighted general good practice and recommended some 'efficiency' process changes and pathway modifications. These changes do not alter the demand and capacity modelling but are aimed instead at appropriate pathway identification and utilisation.

The Urgent Community 2-hour response is also managed by the Community Trust. This service has gathered significant momentum in the last twelve months, with the significant increasing referrals and improved response times which are correlated to reduce ambulance activity.

The main challenge with respect to flow into our Intermediate Care Services / complex discharges into the pathways / demand and capacity modelling, relate to levels of simple and timely discharge activity. To help address this the system commissioned a long length of stay and flow review which was led by Dr Ian Sturgess. The final report has been delivered and work is currently underway to translate this review into a forward action plan. This will identify the main area of work during 2023/2024.
Worcestershire have region leading levels of criteria to reside and low length of stay measures.

National Condition 2 (cont.) Impact on Metrics

- *Unplanned admissions to hospital for chronic ambulatory care sensitive conditions*
- *Emergency hospital admissions following a fall for people over the age of 65*
- *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*

Community hospital provision continues to work across the health and social care system to increase patient numbers admitted directly from home to avoid unnecessary A&E attendances. As outlined above, there are 12 community-based, multi-disciplinary Neighbourhood teams (NTs) within Worcestershire managed by Herefordshire and Worcestershire Health and Care NHS Trust. The teams deliver planned care and intermediate care for both hospital admission prevention and supported hospital discharge. The work NT's, the community equipment service, Pathway 1 + (Wrap Around) and the reablement services deliver across the county has impact upon the unplanned admissions to hospital for chronic ambulatory care sensitive conditions. Their approach within the community and upon hospital discharge also will continue to impact on the number of people aged 65 and over who have an admission into residential and or nursing care homes.

There is innovative work in place across BCF funded services that strive to have impact on hospital admissions following a fall for people over the age of 65. Joint working with Platform Housing ensures that people who have fallen are referred to Neighbourhood Teams for a multi-factorial falls assessment, urgent occupational therapy and/or physiotherapy assessment. Guidelines have been developed jointly to support implementation of this operationally. NTs and LA reablement clinicians now have access to lifting equipment. These teams are working closely with the Ambulance service to identify people who have fallen, don't have injuries and are responding as part of a 2-hour urgent community response (UCR). The people will then receive therapy and Reablement as required. If people do present at the Emergency Department (ED), the UCR hub is supporting with in-reach to try and facilitate a return home rather than an unnecessary hospital admission. The UCR hub is working closely with same day emergency care at the Acute Trust to support with diagnostics and a return home rather than an unnecessary hospital admission. Organisations have worked together to ensure there is a robust offer regarding aids and adaptations. Examples of this can be found in the falls prevention workstream, where work with local providers such as nursing and residential homes have quick access to community services and equipment. Within the hospital, the community equipment stores are available for professionals to refer into, the community OT service provides quick access to routine aids and equipment to either facilitate a discharge home or prevent falls where appropriate. Referrals to this service can be made by any professional to expedite provision in a seamless and effective way. There are some challenges due to resources (OT) in undertaking assessments for individuals in the community, however, Districts are working closely with acute colleagues to further utilise the trusted assessor model and expedite provision through DFG money. Additional work has been undertaken to align policy and procedures to create a more seamless approach to provision. OCT have direct access to refer to all services as do other professionals across place. This does not sit within the homeless in hospital pathway but is an accessible service for all providers to access and utilise as required for the benefit of individuals.

National Condition 3: BCF objective 2: Provide the right care in the right place at the right time.

Approach for integrating care to support people to receive the right care in the right place at the right time. Including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge.

The system has commissioned an integrated intermediate care service approach via a 2-year pilot which has a home first focus. The pilot ends in September 2023.

Worcestershire has seen that overall, most people have received appropriate levels of care in their own homes in a timely manner. This has been achieved through planning in a collaborative way with partners across the system to maximise the use of all available resources. At an operational level the service is working with people and their carers to promote their strengths, making sure people are valued and have meaningful input into arrangements for their discharge plans. Multi-agency triage hubs agree timely discharges which has helped to eliminate delays in allocating capacity and reduced length of stay in hospital. This collaboration has enabled us flexibly utilise resources around the system to target key areas of pressure in the system to maximise flow.

The collaboration between partners and providers created a single trusted assessment document, with an emphasis on a description of care needs, not prescription of pathways to encourage the promotion of the discharge to assess model. This is recognising that people are best assessed in their own environments. The trusted assessment has enabled the system to streamline the processes and reduce hand-offs between partner organisations, ensuring ownership and accountability for decision making and care provision, which in turn has supported the system to improve communication with people, their families, representatives and other care providers.

Community Hospitals take a proactive approach to onward care planning for the most vulnerable people in Worcestershire's health economy. Undertaking regular multi-disciplinary teams' meetings, board rounds and ward rounds with system partners, to ensure effective plans are in place to support people to remain at home.

The Onward Care Team (OCT) is an integrated health and social care service that provides a service into the Acute Trust to support the transfer of care onto community pathways. A person's care needs are described by the ward team and the OCT prescribe the pathway the person is allocated to. The service adopts the home first approach, and most people are supported to return to their own residence (PW0: 11%, PW1: 50%, PW2: 25%, PW3:14%).

The OCT is responsible for managing complex discharges including:

- Repatriation for out of area patients
- CHC funded and fast track discharges
- Nursing and care home placements
- Housing issues and homelessness.

The OCT ensure that discharges are safe and are responsible for managing safeguarding concerns. Complex patients that are ready for discharge are reviewed daily at the discharge cell. The OCTs ensures complex issues are worked through in a timely manner therefore tackling the pressures related to delayed discharge. The enablers for achieving discharges earlier in the day will be through the successful delivery of the

ongoing OCT review actions. Additionally, earlier discharge activity will be achieved through the successful delivery of recommendations from Worcestershire's Dr Ian Sturgess long length of stay review.

Pathway 1 in Worcestershire offers therapy-led services aligned with a Reablement model. People are discharged from a hospital setting through a fully integrated discharge team who provide a proportionate assessment in line with the Discharge to Assess (D2A) model. Pathway 1, returning home, remains the optimum pathway with a previous significant investment to develop further capacity within this service. This is with the desired outcome to enable more people to return home, where safe to do so, in a timely way and reduce the number of people inappropriate occupying a bed-based facility and to benefit from reablement services. Worcestershire County Council have also commissioned the Domiciliary Care sector to deliver a Reablement Focussed Approach which complements the Reablement Service described above, further enabling people to maximise their independence and enabling optimum flow across the whole system.

Following the successful pilot, the Wrap Around service, also known as Pathway 1+, health and care executives are currently discussing the future requirements for the service. The aim of the service is to support people to recover and gain confidence in their own home following a stay in hospital, and to remain at home by delivering 24/7 care in the persons own home for a brief period post discharge. This also allows time to assess and identify any on-going or future care and support requirements. The service focusses on supporting people who are discharged from Acute and Community hospitals and is part of a suite of services for discharge, most especially following a long in-patient stay.

The principles of the service align with:

- Home First
- Focus on people's strengths
- Outcomes

The service is offered on a county-wide basis within Worcestershire. The capacity of the service during its pilot phase was limited to 4 carers initially. There was a staggered start to the pilot service with a two-week lead to ensure time to identify people who are suitable for the service. The service can now support up to 6 people at one time unless 2 carers are required. The duration of care is on average 16 days with significant benefits for the people who have received the service. It has demonstrated a significant reduction in people requiring a care home service once the wrap around service has finished.

Funded through the BCF, the discharge to assess model for people unable to return home under Pathway 3 ensures people can have long term care planning assessments completed in an environment most conducive to their needs. Within this pathway social work colleagues and hospital teams work collaboratively to support people with very complex care needs to leave hospital care to have their long-term assessments completed. The progress of the assessments is regularly monitored and length of stay managed. This ensures that people access the appropriate longer-term care placements as quickly and safely as possible. The collaborative leadership approach has enabled us to break down barriers between organisations and come together with a shared focus. This has also helped to change behaviours and cultures which have previously been a barrier to consistently achieving the right outcomes for people.
A contribution from Worcestershire's BCF is allocated towards packages of care for adults with Learning Disabilities who are eligible for s.117 aftercare. This is for individuals who were previously detained in hospital under the Mental Health Act s3 but have subsequently been discharged into the community. This funding promotes the support to individuals in an environment that ensures they receive the right care at the right time, as a step down from mental health hospital care and support. This could be support provided

within residential care or supported living, dependent on the personalised care and support assessed for the individual.

Worcestershire's BCF also contributes towards the expanded Homeless in Hospital Pathway. This pathway aims to embed the home first approach by early identification of homelessness or housing related issues preventing discharge, whether people are admitted to an Acute Hospital or whether they present at Emergency Departments. Working with the District Councils and their duties under the Homeless Reduction Act 2017 and Worcestershire's Home Improvement Agency which delivers the aids and adaptations service as well as other discretionary services funding via the hospital discharge grant. This this supports discharging people to their usual place of residence and finds alternative accommodation where this is not achievable. Through this pathway, data is being gathered to identify housing related issues that have led to admission and in order to better understand how services can be improved to prevent these admissions. This data will also inform whether step-down accommodation provision is required in the County and what type of units would meet the needs to those unable to return to their usual place of residence on discharge but could do so, longer term, with an interim option. The pathway supports the multi-agency discharge cell work. In turn, this has broadened the cohort of people identified as homeless or with housing related issues preventing discharge. The service also supports hospital teams with people who have complex housing related issues delaying discharge. Correct advice and guidance on what support is available and early identification of these issues will increase system flow over time.

Within the hospital, the homeless in hospital pathway service will be the single point of contact for all housing related discharge referrals. This includes but is not limited to where it is considered the person cannot return home for 'housing' reasons or is homeless. The support provided includes: -

- Early identification within the hospital setting to ensure that the person's housing needs are assessed and acted upon at the earliest opportunity.
- Face-to-face assessments with the person and relevant professionals to establish what is required to safely discharge the person.
- Identification of and access to suitable accommodation which meets their needs but might not necessarily meet all their wishes.
- Identification of need and provision of equipment, furniture and fittings, or anything else that would enable the smooth transition from hospital to the arranged accommodation.
- Signposting/advice/access to complete forms etc to ensure the individual is financially secure regarding income/benefits to cover ongoing accommodation costs, utilities, and day to day provisions.
- Referrals to appropriate agencies across Place to support with health and wellbeing needs and attendance at follow up health appointments to reduce the likelihood of re-admission.
- Facilitation of effective and efficient discharge and prevention of re-admissions for housing needs.
- Oversight of all planned interventions, within agreed timelines.
- Adoption of Consent, Information sharing, Data protection and Freedom of information requirements by all agencies.
- Partnership and collaboration across a wide range of agencies, including but not limited to acute and community hospitals, adult social care, Primary Care colleagues, Care providers, Neighbourhood Teams, District Council Housing and Benefits Teams, Housing Providers, Voluntary and Community Social Enterprise Organisations.

National Condition 3 (cont.) Rationale for the estimates of demand and capacity for intermediate care to support discharge from hospital.

Referrals into the Homeless in Hospital Pathway service in 2022-2023 and improved joint working practices with partners highlighted that only those without an accommodation option were being considered as homeless and requiring support from the previous service. The new pathway increases the number of people eligible to receive the service. This is including those who are unable to return home due to issues with their properties such as cleanliness issues which prevents social care entering the home, hoarding and aids and adaptations such as stairlifts and ramp access.

The cost of living crisis has seen an increase in the number of properties that adult social care identifies as uninhabitable due to damp and mould within the home. Data is being collected around this as District Councils and Housing Associations are asked by the Department for Levelling Up, Housing and Communities to address this. The pathway gathers this data to identify how earlier identification and prevention could prevent hospital admissions.

With the broadening of the definition of homelessness and housing related issues within the pathway this led to a predicted increase in the number of referrals into the service and April 2023 saw a significant increase coming through. At present there is capacity within the inpatient pathway, however, the situation will be monitored and reviewed monthly.

The approach to modelling in this area is based on internal system capacity and demand profiling. Initially the approach was based on that described by Carnall Farrar (External NHS Consultancy) and this has now been adapted for local use.

Modelling is reviewed regularly. Daily and weekly reporting is in place, to allow for immediate actions should significant anomalies occur. Low Levels of outstanding Pathway work, low levels of Criteria to Reside and low LOS measures are all evidence that the basis of the modelling is sound.
The outstanding challenge relate primarily to PW0 activity and actions to rectify this are highlighted above on Pages 10-11.

National Condition 3 (cont.) Impact on Metrics

- *Discharge to usual place of residence*

As detailed above, the Onward Care Team manages the transfers from a stay in hospital to the discharge destination. They are particularly focused on supporting people through a home first approach to impact on the discharge to usual place of residence. This aligns with the direct work by the community equipment service, reablement and Pathway 1 services to support Worcestershire residents to regain their independence, returning and remaining at home.

Pathway 1+, also known as the wrap around service has been expanded and extended during 2022/2023 and future arrangements (for 2023 – 2025) are under discussion. There is potential to increase the capacity to be able to provide support for up to 6 people at one time and for the service to be formally contracted for a 2-year period from September 2023, with a further option for an additional 1-year extension. The purpose of this service is to support people to return to their usual place of residence with an intensive level of care and support for a temporary period. Evidence suggests that people with this level of need would have remained in hospital or, other care and support options would have been considered, delaying the discharge and/or resulting in this cohort of people being unable to return to their own home.

The Neighbourhood Teams provide a 2-hour urgent community response. This is mainly for people in their own homes but if people do present at ED, the UCR hub is supporting with in-reach. This is to try and facilitate a return home rather than an unnecessary hospital admission. The UCR hub is also working closely with SDEC at the Acute Trust to support with diagnostics and a return home rather than an unnecessary hospital admission. The investment into Neighbourhood teams for Pathway 1 in 2021 increased capacity to support an additional 9 patients per week across the county home from hospital. NTs work collaboratively with the LA's Reablement service daily to agree which patients would benefit most from health led Reablement. In addition, should a person deteriorate once home, NTs can support to prevent a potential re-admission and take over the care/reablement as appropriate.

The Homeless in Hospital Pathway aims to gather the data to inform how we change services to provide the right care, in the right place, at the right time in relation to those experiencing housing related issues or homelessness, so delaying discharge. It will identify the housing tenure of people admitted which has not been gathered previously to understand gaps in provision of other services such as those who are ineligible for grants for aids and adaptations but who decline assistance for financial reasons. The pathway aims to support individuals in discharge to their usual place of residence whilst learning from those who are unable too. Having specialist support around the housing and homelessness legislation has increased referrals into the service. It is anticipated that as the pathway is embedded it will support the ambition to improve the waiting time in relation to discharge to usual place of residence.

National Condition 3 (cont.) Implementing the High Impact Change Model for managing transfers of care.

Current Sit Rep on Transfer of Care Hub:

- The Transfer of Care Hub is delivered by our Onward Care Team whose workforce is multidisciplinary from across the system
- It is delivered by the Herefordshire & Worcestershire Health & Care Trust and provides a service across Worcestershire
- Its processes 10 to 15% of total discharge activity from the Acute Trust
- It has an executive senior responsible owner from Herefordshire & Worcestershire Health & Care Trust
- It has agreed local governance
- It receives and process PID
- Decisions are based on real time data
- It is the system's source of demand and capacity information relating to complex pathways
- The Hub facilitates transfers of people between 08:00am and 17:00pm 7 days per week – as part of the recent review into the service it will broaden this functionality to 08:00am to 20:00pm 7 days per week
- The Hub operates with a Trusted Assessor Process and its team are actively involved in discharge planning at a ward level

Areas of development for 2023/2024:

- Improved co working and utilisation with Third Sector Partners
- Left shift from P2 activity to increasing P1 activity
- Improve the 17:00 to 20:00 functionality

National Condition 3 (cont.)

Use of BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered.

In addition to the main BCF resources and plans, the improved Better Care Fund (iBCF) allocation for Worcestershire Adult Social Care in 2023-2025 includes funding to be spent for the following purposes:

a) Meeting adult social care needs
b) Reducing pressures on the NHS including seasonal winter pressures
c) Supporting more people to be discharged from hospital when they are ready
d) Ensuring that the social care provider market is supported

The formal allocation of the iBCF is established as part of the BCF budget setting process, £1m of the total contribution continues to be transferred to NHS Herefordshire & Worcestershire ICB to assist with pressures on the NHS in the relevant areas. The remainder of the grant is used to meet adult social care needs and ensuring that the market is supported, examples of these include:

- Financially supporting the domiciliary care market with the dual aims of avoiding hospital admission and increasing patient flow across the system
- Funding permanent recruitment within the Onward Care Team supporting the streamlining of hospital discharge and reducing the number of people who no longer meet the criteria to reside.
- Additional investment in the community reablement service with the aim of preventing / delaying admission to long term care or hospital.
- The funding of externally purchased Pathway 3 placements, whilst long term care planning for clients.

BCF and iBCF funding is used for key core social care and NHS community services. This includes operational social work, integrated discharge, community health and care services, short-term and long-term placements in home care and care homes, and discharge to assess. It is central to the delivery of health and social care in the community. There is a funded provision for out of hours / enhanced duty social work to provide a rapid response from adult social care in responding to crisis in the community for residents with Worcestershire GPs. This is to deliver a timely response to change of needs of an individual at home who requires an urgent social care assessment to avoid an admission to hospital. Using an enhanced duty service allows referrals to be screened throughout the day, providing an urgent response based on level of urgency and risk. Health colleagues have a point of contact to discuss social care needs when they have urgent concerns causing potential risk of hospital admission. Also, to ensure there is social work capacity to respond to any urgent concerns after office hours to prevent and reduce risks of admission to hospital in the evenings and weekends prior to emergency duty team hours.

BCF funding is used within adult replacement care for block purchase arrangements with care homes and a newly commissioned care home framework. The framework, which will be the focus of sustained development during 2023/24, is intended to ensure individuals and their carers have access to local, bed-based replacement care, which through working in partnership with providers, develops to meet the needs of older people and their families. The framework is to the value of just over £1.5m p.a. and is currently primarily for older people. However, this provision also includes replacement care for people with physical disabilities and sensory impairment and some specific dementia replacement care beds, (with providers who are registered to support these needs). Replacement care for people with a learning disability, mental health or autism is still on a block contract basis. However, this is being reviewed.

Worcestershire County Council also funds replacement care to enable carer breaks which is not within care homes but is within the individual's home. This care is provided by domiciliary care agencies and personal assistants. Care can also be provided outside the usual residence. Care can be paid for and organised by adult social care, or the individual can organise it via a direct payment. The direct payment recipient can manage their own personal care budget.

Replacement care enables unpaid carers to have a break from time to time to enable them to recharge, this was a real issue to achieve during Covid and will be in future, as we learn to 'live' with Covid. This type of provision contributes to reducing carer breakdown, enables the carer to have a life of their own and time to look after their own physical and mental health and wellbeing.

The framework for replacement care is more cost effective than block purchasing for older people, as there was an under-utilisation of the block beds. This model of replacement care is one choice for the carer and cared for. Carers informed the council that the way replacement care is provided can be a restrictive option. This is because not all carers want or need a full week or 2-week break at one time. In response to this feedback, a change was made to the service specification to enable carers to book several days, rather than a full week or two weeks. Providers are given a minimum payment for very short stays to make this a financially viable option for them.

Worcestershire County Council (WCC) contracts with Worcestershire Association of Carers to deliver Worcestershire's 'Carers Hub'. Researched shows the benefits of having a provider independent of the council to provide carer support, encouraging carers to come forward seek support in some circumstances.

WCC delegates the statutory duty of carer assessments out to this voluntary sector provider. There is an entitlement for the assessment of carers needs and to establish how these needs can be met. An approach is used called the 'Three Conversations Model' which uses a 'strength-based approach'. This means carers are put at the centre of the process, identifying a carers' own skills and strengths and what support is available to them in their support network or community (where possible). This type of assessment helps to inform the plan of how to meet the eligible needs of both the carer and the cared for.

The three conversations model will help identify which areas of a carer's life are being significantly impacted because of the necessary care they provide, and the best way to meet those areas of need. Universal services, direct support to the cared for and support for the carer (via the Carers Hub) will collectively meet the carer needs. However, for some carers there may be other unmet needs. A Personal Budget can be allocated to meet eligible needs, which is provided by Adult Social Care and is predominantly taken as a Carer Direct Payment. BCF fund contributes to the Carer Direct Payments to the value of £71,200 p.a. This funding contributes to meeting eligible needs in line with the Care Act 2014.

Carers also informed the council that they like the variety of options WCC offer including domiciliary care and personal assistants both at home and away from the home. If existing domiciliary care packages are in place, the carer break comes from a temporary increase in their domiciliary care package or their direct payment for their personal assistant care hours. The advantage of this is that the carer break can be person centred, for as long or as little as the carers requires and can be within or outside of their home. The carer can choose to remain living at home or go away.

Disabled Facilities Grant (DFG) and wider services

Worcestershire Place is committed to making sure that people admitted to hospital who are homeless, rough sleeping or at risk of becoming homeless are supported with their accommodation needs under The Housing Acts. As part of this commitment, key stakeholders from local authorities, health colleagues and the voluntary and housing sector have come together to develop a seamless pathway to identify individuals at the earliest opportunity and fulfil their duty to refer and provide support/accommodation as appropriate.

The aim of an outcome-based approach is to move the focus from 'tasks' to 'outcomes' and from processes to the way services affect individuals. Success in achievement of outcomes will be evidenced primarily but not exclusively by an improvement of an individual's overall health and wellbeing needs, environmental impact, and satisfaction levels of the individual and their family/carer/advocate as well as service reviews. Services are designed around the individual needs of the person.

Achievement of the individual outcomes should ensure that regardless of an individual's age, circumstances or complexity of their needs, everyone is:

- Valued, this involves being listened to, given options and choices, being kept informed and up to date and that decisions are made about them, with them.
- Supported through change, particularly when moving house, adapting to different support, community, networks.
- Supported to remain safe. Services are coordinated and provided by staff who are well trained and who understand about person-centred approaches to support care and support.
- Treated as an individual. Services are tailored to individual need and offer flexibility and understanding regarding complexities/individual circumstances

Worcestershire's Housing Strategy 2023-2040 (currently being adopted) sets out the shared commitment for collaboration with partners to better integrate with health and care. Health and Wellbeing is one of four key priorities within the strategy and recognises housing's key role in the delivery of health and wellbeing services.

The strategy is overseen by the Housing Board which is attended by a wide range of organisations including health partners. The Housing Board has links to Health and Wellbeing Board which has a representative from housing at the district council and voluntary housing services.

This collaborative approach informs the range of assistance and services offered in the Housing Assistance Policy. The Policy outlines the consistent countywide approach on how we will use the BCF to provide grants and services to enable people to remain safely independent in their own home and avoid unnecessary admissions to hospital, residential and care homes. These services include Dementia Dwelling Grants, Home Move grant assistance, assistance to address fuel poverty and advice on housing options.

These services are delivered through a jointly commissioned home improvement agency integrated with the Worcestershire County Council funded services providing information and advice service on how to remain independent at home and minor adaptations such as grab rails. The home improvement agency also has the support of an in-house occupational therapist.

Where a person needs assistance after a hospital admission, a Heath and Care Trust funded Hospital Discharge worker (employed by a local housing authority) helps to establish a housing pathway and enable swift links to assistance, such as a hospital discharge grant, to facilitate timely discharge from hospital.

Next steps (2023-2025):

- Implement the actions from the Health and Wellbeing priority, in the Worcestershire Housing Strategy, through a new multi-agency task group
- Work with partners and use best practice to develop assistance which efficiently and effectively utilises Worcestershire's additional DFG allocation to support vulnerable people to live well at home.
- Use the home improvement agency recommissioning process to strengthen partnerships and develop our collaborative approach.

Additional information: 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?

The Home Improvement Agency has a flexible DFG funding allocation to meet demand. This is closely monitored to ensure that the districts are able to fulfil their statutory duty. All six district councils within Worcestershire use the funding for discretionary services. In 2023/2024 the spend is projected to be £1m for discretionary services

Equality and health inequalities

How the BCF plan contributes to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics.

In general, the population of Worcestershire is healthy and there are many health-related measures where Worcestershire performs better than the national average. However, there are often smaller places in Worcestershire where people's health is not good, and the average measures reported at County and district council level mask the differences in health outcomes experienced by some communities. Worcestershire has an older age structure than is seen nationally, and the number of older people is increasing. This has consequences for the county in terms of access to services including primary and secondary care settings, general health of the population, ratio of full-time workers to people of retirement age and levels of resources. Malvern Hills, Wyre Forest, and Wychavon all have particularly high levels of older residents. Based on the 2021 census data, almost 22% of the population in Worcestershire are aged 66-plus, with almost 3% aged 85-plus. Proportions of older people are particularly high in Malvern Hills, Wychavon, and Wyre Forest.

Worcestershire has a higher proportion of one-person households where the occupant is of retirement age than is seen nationally, and a lower proportion of lone-parent households. The number of one-person households in which the occupant is of retirement age is increasing. The high proportion of older one-person households could contribute to social isolation and loneliness, as well as potential lack of mobility and access to services and health care, potential increased health concerns and future requirements of access to social care.

The growing and ageing population presents challenges in an increased likelihood of a lengthier stay in hospital and an impact on hospital discharge destination. The BCF plan aims to address these challenges through improved integrated discharge through the onward care team as part of the overall integrated care team. There is a focus on integrated and expanded community services and continuing reablement through discharge to assess and a home first approach and interventions to reduce hospital admissions through the Neighbourhood Teams.

Since the previous BCF plan, Worcestershire's Health and Wellbeing Board has published its Health and Wellbeing Strategy 2022-2032. For the 2022 to 2032 Strategy, the Health and Wellbeing Board identified good mental health and wellbeing as the main priority, supported by action in areas that we all need to 'Be Well in Worcestershire'. The strategy outlines the Health and Wellbeing Board's commitment to improving mental health and wellbeing, supporting people to live well in good health for as long as possible, particularly those who have poorer health outcomes. The Health and Wellbeing Board will champion collective action to ensure children have the best start in life, young people will have hope and aspiration for the future, and residents live longer, more independent lives in good health, with fewer people going on to need care and support which is vital to supporting good mental health and wellbeing.

The BCF plan is an important vehicle for the Worcestershire Health and Care system to support a reduction in unwarranted variation in outcomes. Partners across the system have come together at the Herefordshire and Worcestershire Integrated Care Partnership Assembly to develop and agree an Integrated Care Plan which will share the vision for integrated care, improved health and care outcomes and a reduction in unwarranted variation in outcomes. Underpinning this strategy are the joint strategic needs assessment (JSNA) which provides an assessment of the health needs of the population and focused work to reduce unwarranted variation in outcomes. In Herefordshire & Worcestershire, health provision is working to CORE20PLUS5, an approach to reducing health inequalities and unwarranted variation developed and used across the NHS in England. This focuses efforts to increase tailored support to those living in the most deprived 20% of the national population (CORE 20) and locally define groups including unregistered

populations and those experiencing barriers due to health literacy. The key clinical areas of variation are Maternity, Severe Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis and Hypertension.

The health and care system has commissioned and funded a range of services which directly respond to unwarranted variation, as described in the core20plus5 strategy, as well embedding reducing health inequality through prevention and personalisation through all commissioned services. These principals flow through district collaboratives which bring together district council, county council, health and voluntary sector partners to understand and address local variation. Primary Care are funded to deliver plans focused on reducing unwarranted variation, driven through the district collaboratives. In support of these mechanisms Herefordshire & Worcestershire ICB and Worcestershire County Council have brought funding together to deploy an outreach service. This service will directly work with district collaboratives and communities to provide additional resource and capacity to deliver increased GP registration, health checks and screening within the most deprived communities. The aim is to provide early intervention through a personalised care approach which will see a longer-term reduction in variation and adverse outcomes within key clinical areas such as heart attacks, strokes as well as a range of long-term conditions.

Worcestershire County Council and its partners are committed to the Public Sector Equality Duty (and General Duties outlined in the Equality Act 2010) to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people who share a relevant protected characteristic and those who don't. Ensuring we can evidence 'due regard' in our decision making in the design and delivery of services. It is not envisaged that the content of this plan will negatively disadvantage the following nine groups with protected characteristics: age, disability, gender reassignment, marriage, and civil partnerships (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation.
It is fundamental that individuals and groups are represented, involved and engaged in our activities and services. Partners will work to enable people to access services within the scheme/funded projects, and that support and guidance are provided where necessary to meet all needs, empowering individuals to be independent in the community wherever possible.

Additional ICB Discharge Funding 2023-24 and 2024-25: ICB to HWB allocation template

Guidance

Additional Funding for activity to support discharge from hospital has been provided via ICBs and LAs. This funding must be pooled into local Better Care Fund plans and used in line with the conditions set out in the BCF Planning Requirements.

Half of the Discharge funding has been distributed via ICB allocations. The funding must be pooled into HWB level BCF plans. Allocations to HWB (LA) level have not been set centrally and it is for systems to agree how to distribute this funding at HWB level. The distribution to HWB level should be agreed between the ICB and local authorities.

Agreed contributions from the ICB element of the discharge funding should be included in individual BCF Planning Templates. These HWB allocations will need to be agreed in sufficient time for local BCF plans to be finalised and agreed in time for the 28 June deadline. This template is for ICBs to confirm the distribution of ICB allocated funding across all HWBs within their footprint. ICB finance leads are responsible for ensuring that a completed version of this template is returned for each ICB to england.bettercarefundteam@nhs.net (copied to the Better Care Manager) on 28 June, separately from HWB level plans.

You should ensure that the total sum distributed to HWBs for 2023-24 and 2024-25 from your ICB is equal to the total allocation from the ASC DIscharge Fund.

As with all BCF templates, the information from this template will be shared with national partners, including finance colleagues. ICBs may be asked to report further on the use of this funding during the year.

	Yellow sections indicate required input
ICB name	NHS Herefordshire and Worcestershire ICB

	2023-24	2024-25
Total allocation	£3,143,104.80	£6,666,610.18

Name of person completing this form	

HWB	2023-24 Funding	2024-25 Funding
Herefordshire, County of	£1,047,771.80	£2,221,943.18
Worcestershire	£2,095,333.00	£4,444,667.00
Total (Must equal allocation)	£3,143,104.80	£6,666,610.18

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