Public Document Pack

Health & Wellbeing Board

To:
Councillor Yvette Hopley (Chair)
Councillor Margaret Bird (Vice-Chair)
Councillor Tamar Barrett
Councillor Janet Campbell
Councillor Humayun Kabir
Councillor Joseph Lee
Annette McPartland, Corporate Director Adult Social Care & Health (DASS)
Rachel Flowers, Director of Public Health - Non-voting
Edwina Morris, Healthwatch
Jon Northfield, South London and Maudsley NHS Foundation Trust
Yemisi Gibbons, Croydon Health Services NHS Trust - Non-voting
Steve Phaure, Croydon Voluntary Action - Non Voting
Matthew Kershaw, NHS Croydon Clinical Commissioning Group (CCG)
Debbie Jones, Corporate Director for Children, Young People and Education

A meeting of the **Health & Wellbeing Board** will be held on **Wednesday, 28 June 2023** at **2.00 pm** in **Council Chamber, Town Hall, Katharine Street, Croydon CR0 1NX**

Katherine Kerswell
Chief Executive
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk, Croydon CR0 1EA

Michelle Ossei-Gerning
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www.croydon.gov.uk/meetings
20 June 2023

The agenda papers for all Council meetings are available on the Council website www.croydon.gov.uk/meetings

If you require any assistance, please contact Michelle Ossei-Gerning as detailed above.

AGENDA – PART A

1. Apologies for Absence

To receive any apologies for absence from any members of the Committee.

2. Minutes of the Previous Meeting (Pages 5 - 10)

To approve the minutes of the meetings held on Wednesday 18 January

2023 and Tuesday 21 March 2023 as an accurate record.

3. Disclosure of Interests

Members are invited to declare any disclosable pecuniary interests (DPIs) and other registrable and non-registrable interests they may have in relation to any items(s) of business on today's agenda.

4. Urgent Business (if any)

To receive notice of any business not on the agenda which in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. Public Questions

Public Questions should be submitted before 12 noon on 23 March 2023 to democratic.services@croydon.gov.uk. Any questions should relate to items listed on the agenda. 15 minutes will be allocated at the meeting for all Public Questions that are being considered.

6. Better Care Fund Plan 2022-23 Year End Submission
(Pages 11 - 30)

The Better Care Fund Year End Submission for 22-23 for Croydon to NHS England report is attached.

7. Better Care Fund Plan 2023-25 Submission (Pages 31 - 98)

The Better Care Fund 23-25 planning submission for Croydon to NHS England report is attached.

8. Pharmaceutical Needs Assessment: Supplementary Statement

[To follow]

9. Verbal update on the Workshop

To receive a verbal update on the workshop

10. Exclusion of the Press and Public

The following motion is to be moved and seconded where it is proposed to exclude the press and public from the remainder of a meeting:

"That, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following items of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended."

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Health & Wellbeing Board

Meeting of the Health and Wellbeing Board held on Tuesday 21 March 2023 at 2:10pm in Town Hall, Council Chambers

MINUTES

Present: Councillor Yvette Hopley (Chair)
Councillor Margaret Bird (Vice Chair)
Councillor Tamar Barrett

Rachel Flowers, Director of Public Health - Non-voting
Annette McPartland, Corporate Director Adult Social Care & Health (DASS)
Hilary Williams (South London and Maudsley NHS Foundation Trust)
Mathew Kershaw (Chief Executive and Place Based Leader for Health)
Yemisi Gibbins (Croydon University Hospital, Chair)
Edwina Morris (Chair of Healthwatch, Croydon)
Steve Phaure (Croydon Voluntary Action)

Also Present: Councillor Amy Foster
Councillor Janet Campbell
Shelley Prince (Head of Commissioning and Procurement CYP&E);
Hana Ally (Principal Public Health Analyst)
Jack Bedeman (Public Health Consultant)
Gordon Kay (Healthwatch Croydon Manager)
Rachel Flagg (Joint Director of Transformation and Commissioning, South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust)
Benjamin Jolly (Addington Station Commander, London Fire Brigade)

Apologies: Councillor Maria Gatland
Co-optee Members Steve Phaure (Croydon Voluntary Action);

PART A

2/22 **Disclosure of Interests**

There were no disclosures at this meeting.

3/22 **Urgent Business (if any)**

There were none.

4/22 **Public Questions**

There was one public question received from Councillor Michael Neal:

Constituents that I meet often highlight the fact that it is difficult to obtain Health services for example GP Surgeries, appointments at Hospitals etc, they believe this is due to the many new builds around our District Centres and in particular in our Town Centre / East Croydon area in which there are several hundred new residents.

My question was around data, do you have data determining where new Health Services should be placed? And how do we mitigate that demand to ensure Health Services are spread evenly in the Borough.

In response to the question, Matthew Kerswell addressed that Croydon was a growing borough and in the planning of that growth health did receive dispensation in that the budget was based on population size, and so the bigger the population the bigger the allocation of the budget. There was further investment required for Croydon and progress had been made in some areas for this request. Further, the Board were to continue to identify the needs which helped start conversations to ensure the needs were addressed; this included influencing and persuading, to ensure the borough received the resources required.

7/22 **Healthwatch Croydon Annual Report 2021-2022**

The Health and Wellbeing Board considered the Healthwatch Croydon Annual Report 2021-2022 report, which summarised the work undertaken by Healthwatch Croydon between 1st April 2021 and 31st March 2022. It also set out the priorities and plans for work in 2022-2023 as identified at the beginning of that year.

The Board received an overview from the Healthwatch Croydon Manager, Gordon Kay, who highlighted three of the themes covered in the year:

- Urgent and Emergency Care: Healthwatch Croydon were to provide patient and resident insight on the choice of pathways and their experience of using urgent and emergency care. This survey was undertaken in July 2021 where 1038 completed responses were received. Recommendations included fully integrating pharmacies and GP Hubs into the pathway and support with positive communication; Define NHS111 as the single reliable point of access to direct care to other services; and Understanding services from a user perspective.

- Experienced of Non-English speakers in accessing services: a Croydon version of the Healthwatch England's wider report "Lost for Words" was recently published and was shared with local stakeholders to consider their current services and how they may improve service to those who do not speak English.

- Dentistry: There was a report of Croydon resident's experiences of accessing and using NHS dental services in 2021, which followed the survey that took place between January and June 2021, and had received 150 responses. The recommendations and follow ups included that access needed to be less variable; to undertake a local needs assessment as commissioning has not been reviewed since 2006; to understand the perception of the regular dentist; to prioritise urgent need with regular dentist over check-ups; to provide better information to manage expectations; to communicate costs better and engage with patients

The Chair welcomed the report and the recommendations highlighted within the presentation. It was important for work to be supported.

In response to queries raised by the Board, the Healthwatch Croydon Manager, Gordon Kay clarified the following:

- In relation to the consideration of dentistry and whether the pandemic had an impact, the Board heard that the timing of the survey was not part of the pandemic. The challenges had existed prior, and though not unique Croydon were the most affected due to the commissioning requirements. Rachel Flowers also highlighted the inequalities within the dentistry. Matthew Kershaw highlighted a change within the responsibility of dentistry which currently sat with NHS England would be delegated down to an ICS level focus for dentistry to benefit the services for Croydon.

The Board welcomed the emergency care project which heard the voices of patients of the services provided, to better outcomes which would make a difference to patients.

The Chair thanked the officers for all their work.

The Board **RESOLVED**:

To note the Annual Report of the work of Healthwatch Croydon in 2021-2022, which was attached as an Appendix to this report.

The Health and Wellbeing Board Annual Report 2021-2022

The Health and Wellbeing Board considered the Health and Wellbeing Board Annual Report 2021-2022 report, which provided an opportunity to celebrate all the hard work that had been achieved over the past year by everyone in the Croydon Borough right across the health and social care system, as well as looking ahead to some of the opportunities for the coming year.

The Chair thanked the officers for their hard work over the municipal year.

The Board **RESOLVED**: To

1.1. Report to Full Council the outcome of the Board's monitoring of the delivery plans in fulfilment of the Health and Wellbeing Strategy as part of its annual report; and

1.2. Note the contents of the Annual report in the Appendices Report.

Update on Croydon's JSNA

The Health and Wellbeing Board considered the Update of Croydon's Joint Strategic Needs Assessment (JSNA) report, which was a collection of information relating to the health and wellbeing needs of our population. The report was an update of content that had been added to the JSNA since the topic last came to the Health & Wellbeing Board in October 2021 and a summary of the challenges faced.

The Board received a presentation from the Principal Public Health Analyst, Hana Ally, highlighting the challenges and current view.

The Chair thanked officers involved with this work and acknowledged the challenges and communication outlined in the presentation which required further review and accurate information.

The Director of Public Health, Rachel Flowers, added that a lot of work had been undertaken in Public Health and more improvement was to include more partnership work. The narrative within the data was also important to provide and interpret its meaning.

In response to queries raised by the Board, the Director of Public Health, Rachel Flowers, clarified the following:

- In relation to what further work was required for the joint partnership, and whether the JSNA fit and supported the forward plan and other consistent messages and themes, the Board heard that the challenges included for better multi-agency work in partnership to provide all information in one place. The Head of Commissioning and Procurement CYP&E, Shelley Prince, added that the JSNA was welcomed within their service which was used to utilise information to inform evidence-based commissioning. With a number of strategies refreshed locally the JSNA was the opportunity to feed into the areas, additionally in the way it was engaged, shared and communicated with communities.

The Chair highlighted that there was a lot of initiatives where partners needed to join and support the residents needs and aspirations for better services; this included conversations of taking ownership and resourcing.

Additionally, the Chair noted a lot of change was taking place, which hoped for better outcomes and understanding to the residents.

The Board **RESOLVED**:

1.1. To approve the update to JSNA content

1.2. To note the challenges and, if deemed necessary by the Board, discuss how to overcome these

Croydon Health and Wellbeing Strategy Refresh

The Health and Wellbeing Board considered the Croydon Health and Wellbeing Strategy Refresh report, which was published in 2019 with the vision: “Croydon would be a healthy and caring borough where good health was the default not the exception and those that experience the worst health improved their health the fastest.” The report provided a review and refresh of the Strategy and proposed an approach through which this could be achieved in 2023.

The Board received an overview from the Consultant in Public Health, Jack Bedeman who highlighted shared that the key rationale was that the health and care system were all relevant to the strategy. This followed the Covid 19 pandemic which had highlighted health inequalities and health crisis in cost of living, also the wider health issues including mental health and wellbeing.

The Board welcomed the new joint strategy where services would be able to connect together to add value. There was thought in finding ways to engage with the local community partnership and build into the work and development undertaken to reflect the needs of the community.

The Board **RESOLVED**:

To agree on the process for the review and refresh of the Health and Wellbeing Strategy to cover the years 2024-2029.

South West London Integrated Care Partnership Strategy and Joint Forward Plan

The Health and Wellbeing Board considered the South West London Integrated Care Partnership Strategy and joint Forward Plan report, which South West London were required to produce two plans, a system-wide plan ‘the Integrated Care Partnership Strategy’ and an NHS plan ‘the Joint Forward Plan (JFP)’.

The Board received an overview from the Joint Director of Transformation and Commissioning, South West London Integrated Care Board (Croydon) and Croydon Health Services NHS Trust, Rachel Flagg, who highlighted that the

first part of the plan, the Integrated Care Partnership Strategy, had been discussed at One Croydon Health and Care Board. Some of the discussions included reducing health inequalities. The second part of the plan was the Joint Forward Plan that described how Integrated Care Boards and their partner NHS trusts intended to meet the health needs of their population through arranging or providing NHS services. It would include delivery plans for the integrated care strategy and align with joint local health and wellbeing strategies. The plan was for the priorities of the health and wellbeing to be reflected in the joint forward plan of the NHS.

The Chair noted that there were a lot of strategies which should be based on the public needs, and suggested that all the priorities within the streams would need to align to see where the synergy was.

The Board discussed ideas to the development of the strategies, how it collaborated and delivered with other strategies with other partners.

The Board **RESOLVED**:

1.1. To note the development of the Integrated Care Partnership Strategy for South West London and the process for agreeing the Croydon place response to the draft.

1.2. To provide input to the development of the draft NHS Joint Forward Plan for SWL in terms of the Croydon Health and Wellbeing Strategy priorities that should be reflected.

1.3. To receive a further update on the development of the NHS Joint Forward Plan when it had been drafted.

9/22 **Exclusion of the Press and Public**

This was not required.

The meeting ended at 3:44pm

Signed: .....

Date: .....

LONDON BOROUGH OF CROYDON

REPORT:	**HEALTH AND WELLBEING BOARD**	
DATE OF DECISION	**28th June 2023**	
REPORT TITLE:	**Better Care Fund Plan 2022-23 Year End Submission**	
CORPORATE DIRECTOR / DIRECTOR:	**Annette McPartland** **Corporate Director** **Adult Social Care & Health Directorate** **Matthew Kershaw** **Chief Executive / Place Based Lead for Health** **Croydon Health Services NHS Trust**	
LEAD OFFICER:	**Daniele Serdoz, Deputy Director for Primary and Community care, SWL ICB (Croydon)** **Email: daniele.serdoz@swlondon.nhs.uk** **Telephone: 020 3923 9524**	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**NO**	REASON: The Better Care Fund (BCF) is an annual grant and is one of the Government's national vehicles for driving health and social care integration. It requires the South West London Integrated Care Board (ICB) and Croydon Council to agree a joint plan on how the grant will be used, aligned to the BCF Policy Framework. The plan enables use of pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	Public

1 SUMMARY OF REPORT

1.1 To ensure that both national and local governance is completed correctly, the Health and Wellbeing Board is asked to sign off the Better Care Fund Year End Submission for 22-23 for Croydon to NHS England.

2 RECOMMENDATIONS

For the reasons set out in the report and its appendices, the Health and Wellbeing Board is recommended:

2.1 to sign off the BCF Year End submission for 2022/23 to NHS England.

3 REASONS FOR RECOMMENDATIONS

3.1 Signing off the submission of the end of year report to NHS England sits within the legislative remit of the Health and Wellbeing Board. See section 5 of this report.

4 BACKGROUND AND DETAILS

4.1 The Better Care Fund (BCF) is one of the Government's national vehicles for driving health and social care integration. It requires Place Based NHS ICB's and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These plans enable using pooled funds to support integration, governed by an agreement under section 75 of the NHS Act (2006).

4.2 In Croydon, the Better Care Fund is delivered through the One Croydon Alliance. The Alliance is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning and Population Health Management approaches to improve the lives of people in Croydon.

4.3 The Partners in this Alliance are Croydon Council, South West London ICB (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust; and voluntary sector partners including Age UK Croydon.

4.4 The 22-23 plans were building on progress of previous plans, strengthening the integration of commissioning and delivery of services and delivering person-centred care.

5 APPROVAL OF THE 2022-23 YEAR END SUBMISSION

5.1 The submission deadline for the end of year report was 2 May 2023. We were unable to sign-off the submission by the Board prior to submission due to timings of the meetings.

5.2 However. this year the template has allowed to indicate whether the report had been already signed off at the time of submission, and if not to indicate when the HWBB would sign off the report (Tab 2 of Enclosure 1).

5.3 We were able to agree an interim sign off of the report by the Director of Adult Social Services (DASS) and the Place Based Lead for Health.

5.4 The Year End template was duly submitted, meeting the national deadline of 2 May 2023. This report concludes the second part of the process in relation to the BCF year end template sign off.

6 CONSULTATION

6.1 The 2022-23 year-end submission developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.

7. KEY SUCCESSES AND CHALLENGES NOTED IN THE SUBMISSION

7.1 Most of the BCF schemes in 2022-23 were rolled over from 2021-22 but the ethos shifted toward building on the integration work that Croydon has implemented since 2017 and feed into the Localities Programme of integration in Croydon.

7.2 We have built on previous plans to take into account the increased emphasis on maximising independence and outcomes for people discharged from hospital via our Croydon LIFE service.

7.3 As well as the development of our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon. This is a major programme of transformation and integration that will improve outcomes for Croydon people through a proactive and preventative approach within each of the localities of the borough. One Croydon partners committed to a locality approach via ICN+ as a flagship initiative within our Croydon Health and Care Plan, which aims to deliver the three key objectives, as below.

7.4 We have continued to strengthen Frailty as a key area of work through BCF funding and ICN+, by developing a strategy that joins up acute frailty care with frailty care in the community.

7.5 We have built on a strength based, community-led support approach, which has also been adopted by staff in the Integrated Community Network Plus model in the Local Community Hubs. Staff talk to people about what is important to them and explain what assets are available within local community to support them. The Community Hubs also provide advice about healthy living, housing and benefits.

7.6 Other key changes were the additional investment to support discharges from hospital, with the new ASC discharge fund made available in the second half of last year. Deployment of this funding has once again flagged our system working through the One Croydon Alliance.

7.7 In terms of challenges, Croydon has a very high number of residential and nursing care homes in the borough (128) and while it has a good quality and sustainable market due

to the fact it admits a greater number of its residents to permanent residential placement than it would like to due to a high number of out of borough patients it admits.

7.8 Despite the high number of homes in Croydon there is often still a need to find placements outside of the borough, resulting in the undesirable outcome of an individual being cared for outside of their local area.

7.9 Finally, we continue to struggle with IT interoperability across multiple providers and stakeholders, which provides additional barriers to work seamlessly, sharing records, limiting the discharge process and the ability to develop fully integrated care plans easily accessible by all. There is also a need to create a seamless approach to managing the demand through using our current IT systems in enabling us to better monitor the demand to ensure we have enough capacity to meet needs.

8. LEGAL IMPLICATIONS

The BCF enables the allocation of grant funding between the Council and SWL. The grant funding sits within the Care Act 2014 and within the 2022-23 BCF policy framework, which requires a signed section 75 agreement between the Council and SWL. The agreement was signed on 31st January 2022.

9. EQUALITIES IMPLICATIONS

The report has no changes proposed that affect people, policies, facilities, or processes. An equality impact assessment therefore has not been carried out.

10. APPENDICES

10.1 *A BCF 22-23 Year end submission*

11. URGENCY

11.1 This plan requires sign off by the Health and Wellbeing Board to meet the statutory requirements in relation to the BCF.

Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview
The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS). The key purposes of BCF reporting are: 1) To confirm the status of continued compliance against the requirements of the fund (BCF) 2) To confirm actual income and expenditure in BCF plans at the end of the financial year 3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans 4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above. BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.
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 grey background, as below:
Data needs inputting in the cell
Pre-populated cells
Note on viewing the sheets optimally
To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.

2. The checker column, which can be found on the individual sheets, 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'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. 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:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:

- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:
- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.

5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rurual factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist: Complete:
Health and Wellbeing Board:	Croydon		Yes
Completed by:	Jack Edge		Yes
E-mail:	jack.edge@swlondon.nhs.uk		Yes
Contact number:	2073609326		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Wed 28/06/2023	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Croydon

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Croydon

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	569.0	Data not available to assess progress	There are a number of challenges that the local system is facing, including workforce shortages and exacerbation of long term conditions. We are aware these are national problems and not just for Croydon, but it is	Current performance Q1-Q3 at 470.9. Awaiting Quarter 4 but unlikely we will achieve the target based on local BI knowledge.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.6%	Not on track to meet target	Extremely challenging winter, as evidence by the Q4 data (92.7% vs the planned 93.7%). Compounded by diffciulties with recruitment that continue to hamper progresswith some projects. While the impact of strikes has also	Local BI data - 93.2% - almost on target. Croydon is one of the best performers in SWL on par with Sutton, Merton and Wandsworth. Croydon is just missing the target by a few decimal points.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	290	On track to meet target	The demand for bed based care is still high and increasing as shown by the utilisation of the additional Pathway 3 beds commissioend through the adult social care discharge fund. This is based on existing flow on pathway 2	Whilst initial data shows that we are track to meet the target with us being at 280.60, there has been some work in this area around establishing key home first principals and short term step down beds over the	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	93.3%	On track to meet target	LIFE would like to increase in-house reablement capacity to meet demand. We are looking at ways to reduce therapy waiting time, for example by changing skills mix (converting some of the difficult to	We have introduced and embedded a Trusted Assessors training, and OD culture change training to ensure the foucs remains on reablement, rehab and recovery to prevent residents going on long term care.	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Croydon

Income

	2022-23					
Disabled Facilities Grant	£2,992,679					
Improved Better Care Fund	£9,978,112					
NHS Minimum Fund	£29,339,813					
Minimum Sub Total		£42,310,604				
	Planned		Actual			
NHS Additional Funding	£1,315,000		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£0		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£1,315,000				£1,315,000

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£43,625,604	£43,625,604

	ASC Discharge Fund					
	Planned		Actual			
LA Plan Spend	£1,167,783		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£1,519,666		Do you wish to change your additional actual ICB funding?	No		
ASC Discharge Fund Total		£2,687,449				£2,687,449

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£46,313,053	£46,313,053

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	

Expenditure

	2022-23
Plan	£43,625,604

Do you wish to change your actual BCF expenditure?	No
Actual	

	ASC Discharge Fund
Plan	£2,687,449

Do you wish to change your actual BCF expenditure?	No
Actual	

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Croydon

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly Agree	Our plan for 2022-23 was built upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS partners, the Voluntary Sector, Mental Health and social care which outlines a vision for how health and social care will be delivered across	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Strongly Agree	This year's plan was developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Strongly Agree	The BCF and One Croydon Programme remain the strong foundations for integrated care in Croydon and help us deliver on our strategic commitments on the sustainability of Croydon's health and care services, delivering care where our population needs it and encouraging healthy lifestyles, as well as recognising the need within our transformational work to reduce	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	Checklist Complete:
Success 1	5. Integrated workforce: joint approach to training and upskilling of workforce	We have recruited more integrated workforce to tackle frailty, link in with volunatry sector organisation and brinig care homes into the system. We have continued to run a joined organisational development working group to understand the learning and development needs across the system and increase awareness of and access to training and learning opportunities that are available across	Yes
Success 2	4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production	We have introduced Community-led support across discharge teams. Staff have received training on the 'good conversation' tool. The training will enable them to offer community support and non-funded solutions at the point of options being discussed with patients and families. The Community Connect map will be used as a first point of contact and on triage to inform available alternative options at every conversation with the person. Key features of this approach are: •No decision about a patient's long term care needs should be taken in an acute setting	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	Checklist Complete:
Challenge 1	1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)	Croydon has a very high number of residential and nursing care homes in the borough (128) and while it has a good quality and sustainable market due to the fact it admits a greater number of its residents to permanent residential placement than it would like to due to a high number of out of borough patients it admits. Meaning that residents are not moved onto more suitable longer-term accommodation. Despite the high number of homes in Croydon there is often still a need to find placements outside of the borough, resulting in the undesirable outcome of an individual being cared for outside of their	Yes
Challenge 2	3. Integrated electronic records and sharing across the system with service users	Croydon contiues to struggle with IT interoperobility across it's multiple providers and stakeholders which provides additional barriers to transfering patient records etc limiting the discharge process and the ability to develop intergrated care plans easily accessible by all. There is also a need to create a seamless approach to managing the demand through using our current IT systems in enabling us to better monitor the demand to ensure we have the capacity to deliver .	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Croydon

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.

The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.

1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).

2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.

3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.

4) For 'improvement retention of existing workforce', please state the number of staff this relates to.

5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.

6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.

7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

■

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
12 additional step down beds	Residential Placements	Nursing home	£135,800	£142,246	36	Number of beds	Yes	11 Beds were purchased instead of 12. There was also an increase in the amount spent per bed per week. This meant the spend was £142K for the period up to 31/03/2023.	Yes	Provided valuable Pathway 3 capacity in local Nursing Homes where our local residents can be transferred to whilst waiting for any issues which may be preventing them returning to their	Yes which is being taken forward into designs of new commissioned services
Additional community Equipment	Assistive Technologies and Equipment	Community based equipment	£300,000	£357,258	326	Number of beneficiaries	No	Increased capacity via pathway to support 1 to facilitate discharge	Yes	This supported and helped faciliate capacity for an extraadditional 30 discharges per week via Pathway 1. This also supported the increased ongoing demand for equipment which	Yes which is being taken forward as part of Frontrunner Programme in
Additional discharge staff in LIFE	Additional or redeployed capacity from current care workers	Costs of agency staff	£75,000	£179,385	5,600	hours worked	Yes	We increased the amount of staff available to meet demand via pathway 1 which is included within the figure below	Yes	Case Workers were employed to solely carry out Part B assessments. An average of 15-18 D2A discharges per day Monday - Friday freeing up substantive staff capacity to focus on	Yes which is being taken forward as part of Frontrunner Programme in
Additional home treatment capacity	Additional or redeployed capacity from current care workers	Costs of agency staff	£37,333	£37,333	840	hours worked	No		Yes	2 additional staff members supported discharge into the community from inpatient and ED. 8weeks at 37.5hrs +15hrs Weekends	Yes which is being taken forward as part of Frontrunner Programme in
Additional pharmacy staff to reduce waits for medication on discharge	Additional or redeployed capacity from current care workers	Local staff banks	£23,000	£51,000	525	hours worked	Yes	Increased to provide additional support	Yes	TTA turnaround time to ADU before resource: 56 minutes TTA turnaround time to ADU after resource: 32 minutes	
Administration	Administration		£26,864	£23,392	0	N/A	Yes	Slightly reduced costs incurred	Yes	This covered the costs for the administration of the scheme	
Advance discharge planning liaison	Additional or redeployed capacity from current care workers	Local staff banks	£100,088	£0	0	hours worked	Yes	We couldn't recruit to mobilise the scheme	No		
Bed Bureau contribution to SWL	Residential Placements	Care home	£38,500	£38,500	30	Number of beds	No		Yes	Additional beds provided at a SWL level, created additional bed capacity. Increased capacity of 6 beds across the system	Bed locations created potential barriers for use. We are taking forward into
Bed Bureau staffing	Residential Placements	Care home	£15,552	£15,552	525	Number of beds	No	This is a staffing metric and therefore the number reported is on hours.	Yes	Staffing contribution to support the above beds. This employed an extra 1 member of staff to manage and support use of the beds	Yes which is being taken forward as part of Frontrunner Programme in
Brokerage and placement staffing	Additional or redeployed capacity from current care workers	Costs of agency staff	£48,384	£45,986	1,620	hours worked	Yes	Slightly reduced costs incurred	Yes	4 additional Placement and brokerage staff to help support the additional discharges facilitated by the other projects. This supported as an enabler for discharge and the actual discharge	
CHC staffing	Additional or redeployed capacity from current care workers	Local staff banks	£24,000	£24,000	525	hours worked	No		Yes	Provided additional support for CHC to accommodate additional discharges from the trust. This provided additional assessments and work with families to inform them of the	
Enhanced discharge staff including weekend	Additional or redeployed capacity from current care workers	Costs of agency staff	£60,480	£27,189	525	hours worked	Yes	Reduced amount of staff and funding used elsewhere within schemes to support	Yes	Additional staff within the hospital at weekends to facilitate additional weekend discharges. The fully dedicated service included Therapists, IDTs and Consultants. This supported as an	Yes which is being taken forward as part of Frontrunner Programme in
Enhanced packages (SDS)	Residential Placements	Other	£18,666	£18,666	6	Number of beds	No		Yes	Provided additional fucning to increase the number of packes of care to support discharge. Giving a further 6 beds over a 14weeks.	
Enhanced Primary care support to community discharge	Additional or redeployed capacity from current care workers	Costs of agency staff	£67,000	£90,577	1,258	hours worked	Yes	We repurposed the funding for the scheme below to increase capacity into this scheme	Yes	Paramedic capacity within the Raoid Reponse team. Provided additional capacity within the LIFE discharge team to support more complex discharges. It also provided AHP, drivers and	
Enhanced Primary care support to community discharge	Additional or redeployed capacity from current care workers	Local staff banks	£239,000	£176,771	1,300	hours worked	Yes	We repurposed this money to fund additional capacity for the scheme above	Yes	Extended GP capacity within the Rapid Reponse team. Provided additional capacity within the LIFE discharge team to support more complex discharges. It also provided AHP, drivers and	
Extended equipment service to 7 days	Assistive Technologies and Equipment	Community based equipment	£45,000	£0	0	Number of beneficiaries	Yes	Not used as funded used for increased equipment to facilitate discharge from hospital.	Yes	Provided delivery and install service over 7 days a week rather than 5. creating additional capacity to faciliatet discharges 7 days a week. This supported as an enabler for discharge and the	
Extra supported housing units	Residential Placements	Other	£212,800	£212,800	17	Number of beds	No		Yes	12 Male and 5 female supported housing beds were commissioned to increase capacity within the community to facilitate the discharge of Mental Health patients. It also	
Flow Hub	Other		£360,000	£360,000	12	N/A	No		Yes	Operational 24/7 the flow hub targetted patients suitable for discharge the following morning. The overnight discharge lounge house 12 beds.	
Housing pathway support staff	Additional or redeployed capacity from current care workers	Local staff banks	£90,000	£90,000	2,250	hours worked	No		Yes	A total of 5 staff who faciliated the flow of mental health patients. 12weeks at 37.5hrs/week = 2250hrs	
Increase availability for pathway 1 discharges	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£530,055	£501,458	29,478	Hours of care	Yes	Slightly reduced costs incurred	Yes	Increase of 30 discharges per week for people returing home who need care at home via pathway 1. This is for the increased package if care spend for residents up to 6 weeks.	Yes which is being taken forward as part of Frontrunner Programme in
overspill discharge support	Additional or redeployed capacity from current care workers	Costs of agency staff	£18,666	£18,666	525	hours worked	No		Yes	Dedicated staff member who supported out of area discharge planning for Croydon patients placed out of care. 14weeks at 37.5hrs = 525hrs	
Responsible commissioner identification support	Additional or redeployed capacity from current care workers	Costs of agency staff	£37,333	£37,333	1,050	hours worked	No		Yes	Admin staff who facilated the early identification of reponsible commissioner on admission and information gathering to support funding decisions early in the patients pathway.	
Social work staffing	Additional or redeployed capacity from current care workers	Costs of agency staff	£36,000	£8,115	255	hours worked	Yes	Less hours provided to support within hospital and this was re-purposed to LIFE staffing.	Yes	Provided 2 additional staff and increased operational hours of the team to improve patient flow.	
Staying Put, increased costs and weekend support	Other		£25,000	£25,000	0	N/A	No		Yes	Additional capacity within the Staying Put service for the winter provididing additional blitz cleans, purchasing of key safes and equipment and providing alternative heating arrangements for	
Trusted Assessor model for Home Care Providers	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£21,000	£0	0	Hours of care	Yes	This scheme did not happen and this funded supported the pathway 1	No	This scheme did not happen due to time constraints of delivering the scheme	
Winter bed staffing	Residential Placements	Care home	£26,928	£26,928	0	Number of beds	No	This is a staffing metric and therefore the number reported is on hours.	Yes	Supported the additional 12 Pathway 3 Beds. This provided an extra 2 staff to manage these beds. The actual numbers are included elsewhere within this summary. This supported as an	

Schemes added since Plan											
Enhanced discharge staff including weekends (ICB Funded)	Additional or redeployed capacity from current care workers	Costs of Agency Staff		£104,294	2,250	hours worked	Yes	Additional capacity in the Integrated discharge team funded by the ICB to compliment the staff funded by the LA.	Yes	More workforce capacity to maange complax discharges into the community	

Planned Expenditure	£2,612,449
Actual Expenditure	£2,612,449
Actual Expenditure ICB	£1,444,867
Actual Expenditure LA	£1,167,582

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LONDON BOROUGH OF CROYDON

REPORT:	**HEALTH AND WELLBEING BOARD**	
DATE OF DECISION	**28th June 2023**	
REPORT TITLE:	**Better Care Fund Plan 2023-25 submission**	
CORPORATE DIRECTOR / DIRECTOR:	**Annette McPartland** **Corporate Director** **Adult Social Care & Health Directorate** **Matthew Kershaw** **Chief Executive / Place Based Lead for Health** **Croydon Health Services NHS Trust**	
LEAD OFFICER:	**Daniele Serdoz, Deputy Director for Primary and Community care, SWL ICB (Croydon)** **Email: daniele.serdoz@swlondon.nhs.uk** **Telephone: 020 3923 9524**	
KEY DECISION? [Insert Ref. Number if a Key Decision] ***Guidance**: A Key Decision reference number will be allocated upon submission of a forward plan entry to Democratic Services.*	**NO**	REASON: The Better Care Fund (BCF) is an annual grant and is one of the Government's national vehicles for driving health and social care integration. It requires the South West London Integrated Care Board (ICB) and Croydon Council to agree a joint plan on how the grant will be used, aligned to the BCF Policy Framework for 2023-25. The plan must be signed off by the Health and Wellbeing Board (HWBB), prior to formal submission to NHS England on 28 June 2023. The plan enables use of pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).
CONTAINS EXEMPT INFORMATION? ***(* See guidance)***	**NO**	Public
WARDS AFFECTED:		*All*

1 SUMMARY OF REPORT

1.1 To ensure that both national and local governance is completed correctly, the Health and Wellbeing Board is asked to review and sign-off the Better Care Fund 23-25 planning submission for Croydon to NHS England.

2 RECOMMENDATIONS

For the reasons set out in the report and its appendices, the Health and Wellbeing Board is recommended:

2.1 to sign off the 2023-25 Better Care Fund planning submission to NHS England.

3 REASONS FOR RECOMMENDATIONS

3.1 Sign-off the Croydon Better Care Fund Plans to NHS England sits within the legislative remit of the Health and Wellbeing Board.

4 BACKGROUND AND DETAILS

4.1 The Better Care Fund (BCF) is one of the Government's national vehicles for driving health and social care integration. It requires Place Based NHS ICB's and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These plans enable using pooled funds to support integration, governed by an agreement under section 75 of the NHS Act (2006).

4.2 In Croydon, the Better Care Fund is delivered through the One Croydon Alliance. The Alliance is a health and care partnership created from a shared ambition to use Outcomes Based Commissioning and Population Health Management approaches to improve the lives of people in Croydon.

4.3 The Partners in this Alliance are Croydon Council, South West London ICB (Croydon Place), Croydon Health Service NHS Trust, The Croydon GP Collaborative, South London and Maudsley NHS Foundation Trust; and voluntary sector partners including Age UK Croydon.

4.4 There were minor changes made to the BCF plans from 22-23 and the 23-25 plans build on progress of previous plans. The plans strengthening the integration of commissioning and delivery of services and delivering person-centred care.

4.5 Some of the key changes to the planning requirements from previous years are highlighted below.

- This is a 2-year plan for meeting the BCF national conditions and objectives, covering 23-24 and 24-25.
- The spending plan is also for 2 years. The 24-25 spending plan is provisional for some aspects, where the funding allocations have not been confirmed yet.
- The plan for metrics and for the Demand/Capacity only covers 23-24. Demand and Capacity planning is now a core element of the plan. There is also a new metric on Hospital admissions due to Falls.
- The ICB and ASC discharge funds are also core part of the pooled fund.

4.6 The National Conditions (NC) are:

- NC1 - A jointly agreed plan between local health and social care commissioners and signed off by the health and wellbeing board
- NC2 - Plans to set out 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.
- NC3 - Plans to set out how services the area commissions will support people to receive the right care in the right place at the right time.
- NC4 - Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services.

4.7 Although the majority of the BCF schemes in 2023-25 will be rolled over from 2022-23, the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 to take into account:

- the increased emphasis on providing the right care in the right place at the right time, and improving outcomes for people discharged from hospital via our Croydon LIFE service. Croydon is one of the national Frontrunner sites and the objectives of the programme to transform hospital discharges, align strongly with the BCF objectives;
- the embedding of a neighbourhood approach with our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon working with PCNs to support Croydon people to maintain independence through a proactive and personalised care approach within each of the localities of the borough;
- the additional BCF funding available to support hospital discharges, which has provided the opportunity to increase and align intermediate care capacity in the system in line with the demand and capacity model developed through BCF planning;
- the strengthening of the Croydon frailty and end of life model of care through increased BCF funding and better alignment to ICN+, with acute frailty care strongly joined up with frailty care in the community.
- the significant level of health inequalities experienced in Croydon as highlighted in the Core20+5 analysis and the need to refocus many of the programmes to address inequalities as well as meeting statutory requirements from the Equality Act.

4.8 The BCF and One Croydon Programme are the strong foundations for integrated care in Croydon and help us deliver on our strategic commitments on the sustainability of Croydon’s health and care services, delivering care where our population needs it and encouraging healthy lifestyles, as well as recognising the need within our

transformational work to reduce avoidable hospital admissions and hospital length of stay.

5 ALTERNATIVE OPTIONS CONSIDERED

5.1 This is a nationally mandated programme. Do Nothing is not an option.

5.2 The plan has been carefully considered by the One Croydon partners. Schemes will be regularly reviewed and, if agreed by all partners, alternative options will be proposed on how to redeploy funding within the existing pooled fund.

6 CONSULTATION

6.1 The 2023-25 plan was developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. The One Croydon Governance was used to agree and implement the schemes as planned.

6.2 The One Croydon Senior Executive Group approved the plan on 13th June 2023.

6.3 The Timetable for agreeing BCF Plans and NHSE assurance process are set out below:

Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	28/6/2023- 28/7/2023
Regionally moderated assurance outcomes sent to BCF team	28/7/2023
Cross- regional calibration	3/8/2023
Approval letters issued giving formal permission to spend (NHS Minimum)	3/9/2023
All Section 75 agreements need to be signed and in place	31/10/2023

7. CONTRIBUTION TO COUNCIL AND ONE CROYDON PRIORITIES

7.1 We will live within our means, balance the books and provide value for money for our residents.

7.2 We will focus on providing the best quality core service we can afford. First and foremost, providing social care services that keep our most vulnerable residents safe and healthy.

7.3 We will focus on prevention and proactive care: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early.

7.4 We will unlock the power of communities: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer.

7.5 We will develop services in the heart of the community: giving people easy access to joined up services that are tailored to the needs of their local community.

8. IMPLICATIONS

8.1 FINANCIAL IMPLICATIONS

8.1.1 This report confirms to NHS England that Croydon's 2023-25 Better Care Fund allocations have been allocated within the guidelines of the national Better Care Fund policy framework. It does not impact current budgets.

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

8.1.2 The plan includes a contribution to adult social care from the NHS in line with the required minimum contribution. This is approximately £12.3M in year 1 and £13M in year 2.

8.1.3 The plan also includes a large proportion of NHS commissioned schemes delivered out of hospital. Croydon's BCF investment in NHS commissioned out-of-hospital services will total approx. £17M in year 1 and £18.1M in year 2, significantly in excess of the mandated minimum spend.

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

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

Adult Social Care services spend from the minimum ICB allocations

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

8.1.4 The schemes make a significant contribution to supporting people to remain independent for longer and, where possible, support them to remain in their own home (National Condition 2), whilst also striving to provide the right care at the right time in the right place (National Condition 3). This is through a programme of work centred around hospital discharge improvement and further developing integrated localities team with a focus on neighbourhood and communities to be at the heart of people's care.

Scheme Type	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Assistive Technologies and Equipment	£ 852,953	£ 993,434
Bed based intermediate Care Services	£ 663,514	£ 1,121,342
Care Act Implementation Related Duties	£ 658,000	£ 658,000
Carers Services	£ 227,211	£ 228,619
Community Based Schemes	£ 6,430,487	£ 6,822,602
DFG Related Schemes	£ 2,992,679	£ 2,992,679
High Impact Change Model for Managing Transfer of Care	£ 1,395,000	£ 3,391,742
Home Care or Domiciliary Care	£ 6,707,877	£ 7,026,625
Home-based intermediate care services	£ 2,178,530	£ 2,217,744
Housing Related Schemes	£ 133,000	£ 133,000
Integrated care planning and navigation	£ 6,377,181	£ 6,519,875
Personalised Budgeting and Commissioning	£ 867,526	£ 867,526
Personalised Care at Home	£ 6,584,946	£ 6,692,950
Prevention / Early Intervention	£ 1,033,235	£ 1,051,833
Reablement in a persons own home	£ 2,155,000	£ 2,155,000
Residential Placements	£ 7,464,805	£ 7,611,477
Urgent Community Response	£ 167,211	£ 170,221
Workforce recruitment and retention	£ -	£ 122,394
Grand Total	**£ 46,889,154**	**£ 50,777,063**

8.1.5 As such, our plan meets the BCF national conditions, which were set out in the Planning Requirements published on 5th April 2023.

8.2 LEGAL IMPLICATIONS

8.2.1 The BCF enables the allocation of grant funding between the Council and SWL, with a minimum SWL contribution to the Council for ASC of £11.8M. The grant funding sits within the Care Act 2014 and within the revised 2023-25 BCF policy framework, which requires a signed section 75 agreement between the Council and SWL. The agreement must be signed and submitted to NHS England by 31st October 2023.

8.3 EQUALITIES IMPLICATIONS

8.3.1 There are no changes proposed to existing schemes in this report that affect people, policies, facilities, or processes. An equality impact assessment therefore has not been carried out.

8.3.2 For any new scheme implemented over the course of the next two years, equality impact assessments will be undertaken as part of the business case development.

9. APPENDICES

9.1 *1 BCF 23-25 Planning Template*

2 BCF 23-25 Narrative Template

10. URGENCY

10.1 This plan requires sign off by the Health and Wellbeing Board ahead of submission.

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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.

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

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

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Croydon

Income & Expenditure

Income >>

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

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

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

Adult Social Care services spend from the minimum ICB allocations

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

Metrics >>

Avoidable admissions

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

Falls

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

Discharge to normal place of residence

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

Residential Admissions

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

Reablement

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

Planning Requirements >>

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

Better Care Fund 2023-24 Capacity & Demand Template

1. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

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

3.1 Demand - Hospital Discharge

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

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:

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

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

3.2 Demand - Community

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

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

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

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

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

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

3.4 Capacity - Community

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

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

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

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

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

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	More information in the narrative document.	Complete:
		3.1 Yes
	Margin of Error	3.2 Yes
	Following a review of the data from this and previous years we believe there is a variance or margin of error on predicted demand of between 7 – 10%. This number is higher than what we would have like to see but we are in the process of introducing new systems and measures that will allow us to refine our predictive model that will improve future forecasts. Also many assumptions have not been able to	3.3 Yes
		3.4 Yes

3.1 Demand - Hospital Discharge

Demand - Hospital Discharge

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

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

3.2 Demand - Community

Demand - Intermediate Care													
Service Type	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Social support (including VCS)	77	77	77	77	77	77	77	77	77	77	77	77
Urgent Community Response	374	293	334	356	341	330	431	362	468	374	381	406
Reablement at home	89	89	89	89	89	89	130	130	130	130	130	130
Rehabilitation at home	5	5	5	5	5	5	5	5	5	5	4	4
Reablement in a bedded settine	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded settine	4	4	4	4	4	4	4	4	4	4	4	4
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

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

3.4 Capacity - Community

Capacity - Community														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	**Metric**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**ICB**	**LA**	**Joint**
Social support (including VCS)	Monthly capacity. Number of new clients.	81	81	81	81	81	81	81	81	81	81	81	81	100%		
Urgent Community Response	Monthly capacity. Number of new clients.	374	293	334	356	341	330	431	362	468	374	381	406	100%		
Reablement at Home	Monthly capacity. Number of new clients.	87	87	87	87	87	87	130	130	130	130	130	130			100%
Rehabilitation at home	Monthly capacity. Number of new clients.	3	3	3	3	3	3	5	5	5	5	4	5			100%
Reablement in a bedded settine	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Other short-term social care	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2	2	2		100%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Croydon

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

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

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

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

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

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

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

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

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

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

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

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Croydon

<< Link to summary sheet

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

Required Spend

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

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

Checklist

Column complete:

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

>> Incomplete fields on row number(s):

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

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

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

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

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

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

Further guidance for completing Expenditure sheet

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

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

2023-25 Revised Scheme types

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

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

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

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

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Croydon

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

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

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

8.2 Falls

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

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

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

8.4 Residential Admissions

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

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

8.5 Reablement

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

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

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

Better Care Fund 2023-25 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Croydon

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

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes				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				Yes

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

COVER

Health and Wellbeing Board

Croydon

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care in Croydon.

Bodies involved include:

- SW London ICB (Croydon Borough)
- London Borough of Croydon
- Croydon Health Services
- Age UK Croydon and other VCS organisations
- South London and Maudsley NHS FT
- Croydon GP Collaborative.
- Local Care agencies, including care providers and care home

How have you gone about involving these stakeholders?

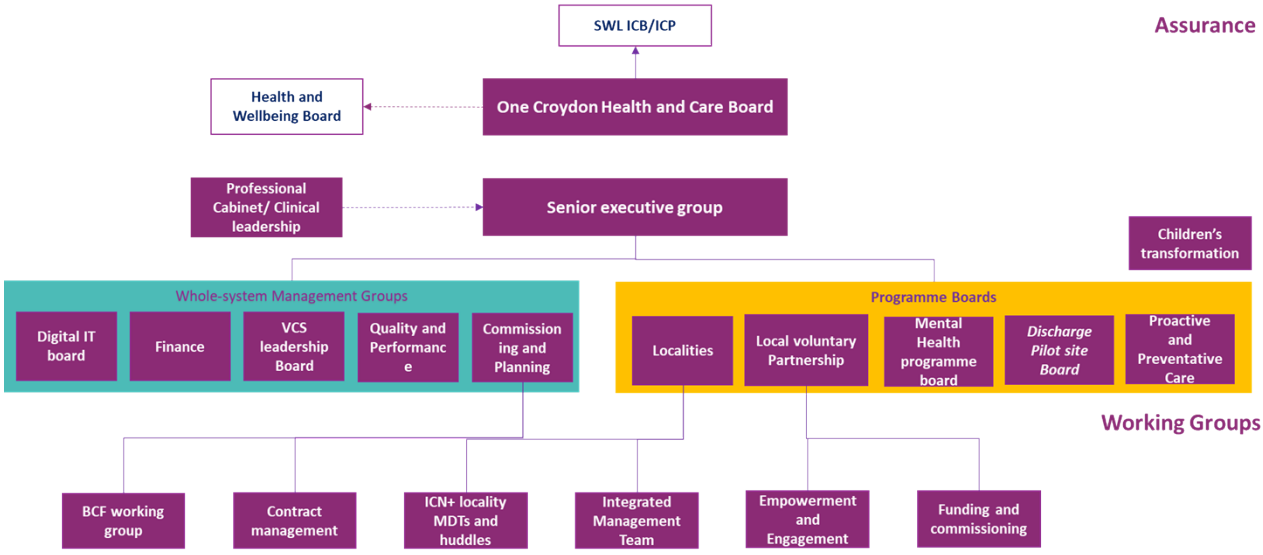
Stakeholders have been involved via the One Croydon Alliance groups such as: the BCF working group, Localities Board, the Senior executive Group. This has included colleagues from Health, Social Care and Housing who have engaged via the Council participation into the BCF working group as a starting point. This year we have also had significant further engagement through the Frontrunner governance, including the design groups and workshops undertaken to understand the challenges and design the new model with all system partners.

GOVERNANCE

Please briefly outline the governance for the BCF plan and its implementation in your area.

On 1 July 2022, we launched South West London (SWL) Integrated Care System (ICS) as we take on health and care statutory responsibilities in line with the new legislation, outlined in the 2022 Health and Social Care Act. The introduction of the SWL ICS will only strengthen the already established One Croydon partnership as well as further ensure that local people receive the best care.

One Croydon Alliance introduced a number of whole system groups, which has allowed One Croydon the opportunity to fully embed the BCF management and oversight within the local governance. Amendments have been reflected in the BCF S75 as well as the appropriate Terms of Reference.



Health and Well Being Board

Croydon Council's constitution has changed from an Executive Leader and Cabinet Model, to a directly elected Mayor, and in May 2022 the residents voted in a new Mayor. Proposals have been made to amend the Terms of Reference of the Board to make provisions for delegated authority to key decision makers to sign-off BCF plans, with plans brought to the Board for ratification. We are anticipating the BCF plans will be signed off at the next Board meeting which will take place on the 28th of June 2023, the same day of the national submission.

BCF Executive Group & SEG

Historically, final BCF signoff was to be completed by the BCF executive board. However, as the key members of this executive board already sit within the Senior Executive Group (SEG), within the current one Croydon governance in 2021 it was agreed that the BCF executive boards functions are subsumed into SEG. SEG reports into the Shadow Health and Care Board, which feeds into to the Croydon Health and Wellbeing Board.

The role of the Commissioning and Planning Group

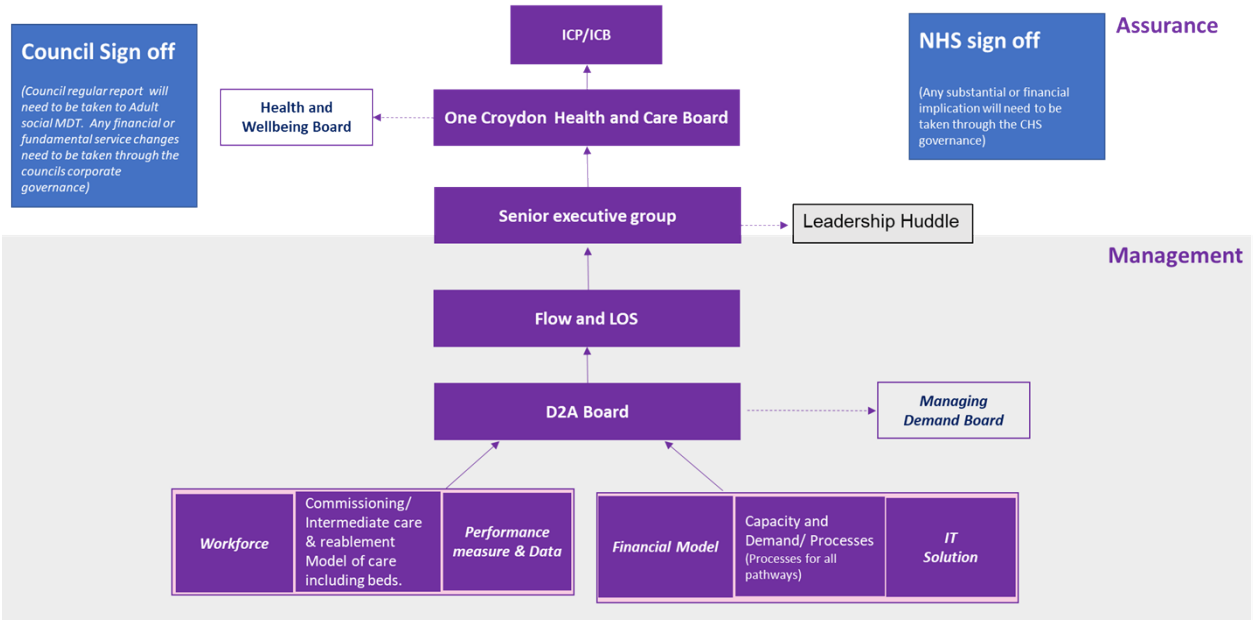
With the introduction of the Commissioning and planning group, there now exists a governing board that can apply oversight to BCF requests and proposals prior to final agreement by SEG. Although not responsible for drafting proposals the group is responsible for discussing and approving proposals with all relevant One Croydon professionals.

BCF working group

To facilitate the process of reviewing, planning and developing BCF spend options, a BCF working group was established by commissioners from health and social care in 2021. This group includes stakeholders from across Croydon, Finance leads, Commissioners, Head of Improvement and Policy, One Croydon leads and the DFG lead. The group takes all reviews, options and proposed changes to the Commissioning and Planning Group prior to any final submission to SEG for agreement.

New Discharge Transformation Governance

As part of the Frontrunner programme, Croydon is reviewing its model of care for supporting discharge from hospital and intermediate care offer. Many of the pathways and services to support discharges are funded through the BCF. Therefore, it was imperative to ensure that the two governance routes are aligned through the Senior Executive Group.



EXECUTIVE SUMMARY

This should include:

- Priorities for 2023-25
- Key Changes since previous BCF plans

This document sets out Croydon's Better Care Fund Plan for 2023/25. It complements the BCF Planning Template which will be submitted together with this narrative. This BCF narrative document and the Planning template will show that Croydon BCF plan for 2023-25:

- Has been jointly agreed between health and social care partners. This plan has been developed with input from the One Croydon Alliance partners and wider stakeholders in health and social care. As outline in the previous section of this document the One Croydon Governance has been used to agree the plan, which will then be signed off by the Health and Wellbeing Board (National Condition 1).
- Includes a contribution to adult social care from the NHS in line with the required minimum contribution (National Condition 4)
- Makes a significant contribution to supporting people to remain independent for longer and, where possible, support them to remain in their own home (National Condition 2), whilst also striving to provide the right care at the right time in the right place (National Condition 3). This is through a programme of work centred around hospital discharge improvement and further developing integrated localities team with a focus on neighbourhood and communities to be at the heart of people's care.

Our joint priorities are outlined in the next section ("Overall BCF plan and approach to Integration"). Our plan for 2023-25 builds upon established joint working in Croydon through the One Croydon Alliance and the delivery of the Croydon Health and Care Plan. This is a fully integrated programme of work between NHS partners, the Voluntary Sector, Mental Health and Social Care which outlines a vision for how health and social care will be delivered across the borough, particularly for those with the greatest need, to transform the health and wellbeing of local people and address the significant level of health inequalities experienced by our local communities. The plan emphasises three clear priorities:

- Focus on prevention and proactive care: supporting people to stay well, manage their own health and maintain their wellbeing by making sure they can get help early.
- Unlock the power of communities: connecting people to their neighbours and communities, who can provide unique support to stay fit and healthy for longer.
- Develop services in the heart of the community: giving people easy access to joined up services that are tailored to the needs of their local community

Key Changes since previous BCF plans

Previous BCF plans for Croydon focused on delivery of improved integrated community services that enabled people to receive the care they need at home or close to home. In so doing, reduce demand on acute health services and help maintain their independence and, as a consequence, reduce dependence on statutory services. These services included:

- Proactive and personalised care through the implementation of multi-Agency Huddles (including social workers) which are GP practice based and locality MDTs (ICN+)
- LIFE service (Living Independently for Everyone) to deliver our Croydon Discharge to Assess model, including reablement/rehabilitation in the community

- Other integrated neighbourhood-based services for Diabetes, COPD and Cardiology, contributing to addressing health inequalities in core 20+5 populations in the Croydon localities
- Increased investment in Frailty, Falls and End of Life Service
- Community Mental Health offer to support early discharge as well as admission avoidance.

All these service initiatives were supported through a range of other enabling projects including assistive technology, carer support, housing service (such as Staying Put), as well as additional social work support in working with the hospital to avoid admission to hospital through emergency care and facilitate timely and safe discharges.

Although many of the BCF schemes in 2023-25 will be rolled over from 2022-23, the ethos has shifted toward building on the integration work that Croydon has implemented since 2017 to take into account:

- the increased emphasis on providing the right care in the right place at the right time, and improving outcomes for people discharged from hospital via our Croydon LIFE service. As described later in the document, Croydon is one of the national Frontrunner sites and the objectives of the programme to transform hospital discharges, align strongly with the BCF objectives;
- the embedding of a neighbourhood approach with our Integrated Care Network Plus (ICN+) model of care in the 6 localities in Croydon working with PCNs to support Croydon people to maintain independence through a proactive and personalised care approach within each of the localities of the borough;
- the additional BCF funding available to support hospital discharges, which has provided the opportunity to increase and align intermediate care capacity in the system in line with the demand and capacity model developed through BCF planning;
- the strengthening of the Croydon frailty and end of life model of care through increased BCF funding and better alignment to ICN+, with acute frailty care strongly joined up with frailty care in the community.
- the significant level of health inequalities experienced in Croydon as highlighted in the Core20+5 analysis and the need to refocus many of the programmes to address inequalities as well as meeting statutory requirements from the Equality Act.

The BCF and One Croydon Programme are the strong foundations for integrated care in Croydon and help us deliver on our strategic commitments on the sustainability of Croydon's health and care services, delivering care where our population needs it and encouraging healthy lifestyles, as well as recognising the need within our transformational work to reduce avoidable hospital admissions and hospital length of stay.

Please note that there is also a SWL review of the Better Care Fund across all Boroughs. This review is expected to be completed in the Autumn and may inform some further changes for next year.

NATIONAL CONDITION 1: OVERALL BCF PLAN AND APPROACH TO INTEGRATION

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- **Joint priorities for 2023-25**
- **Approaches to joint/collaborative commissioning**
- **How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.**

Joint Priorities for 2023-25

Local NHS, Croydon Council and Voluntary and Community Sector (VCS) partners have been collaborating as the One Croydon Alliance since 2017. One Croydon is an established place-based partnership responsible for setting the strategic direction for health and care in Croydon and for overseeing the embedding of an integrated, person-centred health, social care and housing programme of transformation.

Our vision is to deliver better care and support that is tailored to the needs of our communities and available closer to home. We will meet this ambition by bringing together the borough's NHS physical and mental health services, along with general practice, council and the voluntary sector, joining up services to provide more holistic care. The BCF is a crucial enabler for achieving this vision.

Our Health and Care Plan is aligned to the broader Health and Wellbeing Strategy set by the Health and Wellbeing Board and outlines the Joint Priorities for the Croydon system over the next 2 years, as outlined below.

Live well – To give working age people the best support, we set out to:

1) Help them manage their Long-Term Conditions, aiming to work with general practices to identify those who would benefit from holistic assessment and personalised care planning and provide appropriate support across health and care system.
2) Reduce Health Inequalities, prioritising programmes that will identify and or look to reduce health inequalities within Croydon.
3) Improve Mental health & Wellbeing, focusing on prevention of admissions and facilitating early discharge, key BCF funded programmes such as the Home Treatment Team and MH Packages of Care will continue working proactively to support people with complex mental health needs accessing the new MH Step-down beds if required.

Age Well – To support our older residents the best we can, we set out to:

1) Continue to improve our Frailty and personalised care programmes, embedding an approach where consideration of frailty needs is 'everybody's business'
2) Help residents maintain their independence for as long as possible, delivering on the ambitions of the NHSE Discharge Integration Frontrunner programme, of which Croydon is one of six national sites.

3) Support people to live and die with dignity, embedding services to support early discharge from hospital of people on an end-of-life pathway, with continuity of care across community services including those provided by St Christophers Hospice via the Choose Home service.

Golden Threads

1) Integration and Neighbourhood development – bringing together primary and secondary social and health care services, along with local VCS partners, to provide more coordinated care and tailoring our local offer to give people greater control of their health and build resilient and healthier neighbourhoods.
2) Supporting carers – with a commitment to the development of a One Croydon Carers strategy and delivery plan that will look to ensure that the people who support are themselves supported appropriately.
3) Workforce - Strengthening the roles of social prescribers; community connectors, wellbeing coaches and other allied health professional roles and build a workforce able to make interventions to tackle social inequalities, help people improve their lifestyles and, hence, their health outcomes.
4) Proactive and Preventative care, helping people to stay well and reduce the risks to their health from long-term conditions.

Approach to collaborative commissioning

Healthy Communities Together

Our commissioning partnerships with local communities and the voluntary and community sector has been strengthened through the Healthy Communities Together programme, funded by the National Lottery, to build and strengthen Local Community Partnerships in each of Croydon's six ICN+ localities. As part of this, a locality-based commissioning model has been created, with the principle to shift spend and activity into the Voluntary community sector over time. This is to be informed by an evidence-based approach to address health inequalities, improve outcomes, manage demand whilst delivering better value. A locality-based process for grants allocation has been developed. The recommissioning of the BCF funded End of Life respite service is an example of this approach.

The Frontrunner Programme

Croydon has been selected as one of the six (6) NHSE Frontrunner sites. The high-level aim of the Discharge Integration Frontrunner programme is to develop an effective, integrated care provision across the One Croydon Alliance. One of the key outputs of the programme is to develop an integrated Transfer of Care Hub (TOCH) which will be a fully resourced team to include our reablement offer. Building on the successes of the integrated LIFE team launched in 2018, BCF funding will be used jointly by the NHS and the Local Authority to support the Frontrunner program in transforming care.

Developing an effective, integrated system (community and hospital discharge) will require a joint approach to commissioning services in particular our resources. It will also require us reviewing and redesigning our patient pathways to incorporate health, social and housing to ensure services are fully embedded, centred around the residents in Croydon and sustainable.

Other examples of collaborative commissioning

A few examples of how we work collaboratively in commissioning include:

- Working together to commission BCF funded intermediate care rehab bed provision through a joint commissioning approach for nursing home beds.
- Commission services collaboratively with the council using the recently introduced Adult Social Care Discharge funding; for example, commissioning Pathway 3 step up and Step-down beds as well as Mental health beds, to support hospital discharges and improve flow.
- Use of Section 75 agreements to pool funds or delegate commissioning responsibilities for services such as the community wheelchairs service and the community Equipment service - both provided by the Council's in-house Croydon Equipment service (CES).
- Collaborative commissioning of a falls pick-up service as part of the BCF funded, Council's Careline service.
- CHC supporting and placing residents on D2A pathway 3 into Nursing Homes
- Croydon has 128 registered care homes and the largest Care Home provision within London with over 3000 beds. The Council and the ICB's CHC team are working in partnership to develop the Care Home market, especially Nursing Homes Looking at market trends for ongoing commissioning pathways.
- Providing dedicated support and training to care homes through various mechanisms including dedicated webpages, webinars, training sessions and recruitment campaigns.
- We have an Integrated Mental Health Placement Review team and approach to s117 aftercare needs with key partners SLP, SLaM, Council and SWL ICB.
- Supporting increased use of equipment/assistive technology in supporting hospital discharges through the pooled equipment budget.
- Looking at technology to join up IT systems to improve data flow and intelligence to speed up discharge planning.

Changes to previous BCF plans

Most of the BCF schemes funded in 22-23 will roll over into 23-24 and 24-25. The ethos however has been to build on the integration work that Croydon has implemented since 2017 through the One Croydon Alliance of health and care. Some of the changes in this and next year's plan are briefly listed below.

- All schemes have been reviewed, funding redistributed and re-aligned to reflect current programs of transformation and integration of health and social care, such as the ICN+ and the LIFE programs, the Mental health Programs and the integrated Same Day Emergency Community offer.
- Some further investment in our offer to support people manage their long-term conditions in the heart of their communities, eg Asthma and COPD through a neighbourhood approach.
- More funding has been allocated to End of Life, Frailty and mental health initiatives, both from the NHS minimum contribution and the Discharge Funding as outlined later in this document. For example, Choose Home and Advanced Care Planning Practitioners, which support people on an end-of-life pathway to die in their preferred place.
- Much of the iBCF schemes have also refocused on packages of care to support reablement and Discharge to Assess.
- Expansion of the carer's support offer to expand the range of respite services, increasing the reach of emotional support services, linking with health and care services and modernising the digital support offer.

- New funding has been allocated by both the ICB and the Local Authority to support the Discharge Integration Frontrunner Programme as the new model of care is developed over the course of the programme. This is expected to be piloted in the second half of 2023-24 for full implementation in 2024-25. This will improve outcomes for people discharged from hospital.
- A Home from Hospital Service provided by the VCS is also being redesigned and funded through BCF. This is in addition to a Red Bag coordinator based in the hospital discharge team, supporting the hospital discharge pathway into care homes.
- The new ASC and ICB Discharge funding has also been agreed and allocated, with some schemes rolled over from 22-23 following an evaluation, and others newly implemented to create additional intermediate care capacity and support hospital discharges, as informed by an analysis of demand and capacity.

All adults in Croydon (>18) are in scope for our initiatives.

NATIONAL CONDITION 2

Use this section to describe how your area will meet BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Main schemes relating to NC2: Schemes 1,2,3,6,7,8,9,10,11-16,18,19,20,21,26,27,31,33,38

Please describe the approach in your area to 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. This could be:

- **Steps to personalise care and deliver asset-based approaches**
- **Implementing joined up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches**
- **MDTs at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake**
- **How work to support unpaid carers and deliver housing adaptations will support this objective**.

To enable people to stay well, safe and independent at home for longer, One Croydon partners committed to a Locality approach that aims to engage our local communities in co-producing services and activities and to deliver integrated, proactive care and support close to home by shifting power to local people and developing neighbourhood-based networks.

To deliver the above vision Croydon continues to develop and evolve the Integrated Community Networks Plus (ICN+) model of care in 6 Localities (aligned to PCNs), a flagship initiative within our Croydon Health and Care Plans.

Over the past year the model was reviewed and continues to be refined against the national requirements of proactive care, personalised care, the findings of the Fuller report as well as local learnings, with significant alignment already in place and improvement plans being articulated. There remains focus on people with multiple Long-Term Conditions, frailty and high usage of unplanned care services.

As such, the programme's current emphasis is to continue establishing effective ways of working that facilitate coordination and delivery of proactive and personalised care in the community via cross-system multidisciplinary teams (MDT) and by making every contact count, working toward health and social care integration of core community-based services.

In summary the two-year focus is on:

1. Supporting existing core community-based services to work in a holistic way and make every resident contact count, building professional networks with colleagues who support residents in the same geographical area (Locality aligned to PCNs)

2. Delivering effective and timely Neighbourhood Multidisciplinary team (MDT) working for residents identified in the community that would most benefit from coordination, care planning and proactive management via cross-system MDT Huddle discussions and joint working

3. Supporting best practice and quality improvement for the above via a Neighbourhood based coordination function that oversees all cases discussed and supported via MDTs as well as supports skills development and information sharing efforts between and beyond the core teams

To ensure strong asset-based and preventative focus six Local Community Partnerships (LCPs) were established by VCS partners to draft neighbourhood led Community Plans, ensuring greater local ownership, collective voice, and leadership. Each LCP is also developing Community Hubs to provide pathways for people into social support networks, community-led activities and specialist voluntary and statutory services, with preventative health and wellbeing programmes delivered from the hubs. There are currently three Community Hubs set up by the VCS in venues that are known and accessible to local residents. There are plans for at least one community hub in each of Croydon's six localities. The community facilitators are part of the MDTs in each of the six localities and ensure a strong link with the Hubs.

Roles and initiatives funded by the BCF, including ICN+ Teams, Proactive Care, Personal Independence Coordinators and Frailty Practitioners, are fundamental to progressing the development of the model and supporting operational development of the MDTs, and are aimed at:

- Undertaking early identification and providing oversight of cases put forward for MDTs, including being patient centred and ensuring a supportive assessment - building on intrinsic abilities of resident and support network
- Ensuring that validation, agreement and review of personalised plans at cross-system MDT meetings are solution focussed, including consideration of non-clinical needs – solving problems by working jointly and actioning appropriate interventions, ensuring streamlined access to wider support services, and only referring to other teams when there is a specific need
- Enabling increased joined up working and coordination of care in between MDT meetings via established professional networks
- Delivering timely intervention through community-based services, including e.g., personal independence coordinators, social care support and wider voluntary sector services - maximising independence and self-management
- Optimising use of health and social care services (reducing unnecessary interventions/ admissions).

In addition to the proactive care and MDT approach for all residents, the Croydon EOL steering group has been focussed on the development of services to maintain a personalised care approach, addressing health inequalities for those at end of life, and supporting people to die in their place of choice. In Croydon there is a significant variation in the completion of advance care plans based on ethnicity and health inequalities (the 'Core20' have a lower proportion of care plans and a higher average mortality risk). In addition, currently 50% of people at end of life die in hospital.

Population health management approach

The shift into Integrated Care Systems (ICS) presented an opportunity to create an aligned approach to improving population health across South West London (SWL) and use the increasingly rich data available to target those in our communities with the greatest need, to focus more on prevention and population health improvement, using a Population Health Management (PHM) approach.

During 2022 we worked with our health and care partners from across to develop and publish the South West London Population Health Management PHM Roadmap, which sets out the steps we need to take together in our six boroughs. to deliver a strong PHM approach in SWL.

In SWL we have developed Health Insights, a data/analytics platform which has been built using Microsoft Power BI and presents data from various sources using interactive dashboards; we also have a SWL BI/Analytics team who can provide more sophisticated data and analytics functions, as well as create bespoke dashboards to support our work programmes.

Working as a system, our health and care services can work together to design new proactive models of care which will improve health and wellbeing today as well as in the future. This means we can tailor better care and support for individuals, co-produce and design more joined-up and personalised care with our communities (patient segments or identified cohorts) and make better use of public resources for example the development of integrated multi-disciplinary neighbourhood teams (Fuller Stocktake).

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- **Learning from 2022-23**
    - **Where number of referrals did and did not meet expectations**
    - **Unmet demand**
    - **Patterns of referrals and impact of work to reduce demand on bedded services**
- **Approach to estimating demand, assumptions made and gaps in provision identified**
    - **Where have you estimated there will be a gap between demand and capacity**
    - **How have estimates of capacity and demand been taken on board and reflected in the wider BCF plans**

Our demand and capacity analysis suggests that our capacity for community referrals broadly matches demand. Referrals into intermediate care services from the community are relatively low as more focus is given to hospital discharges. One of the key aspects highlighted by this analysis is the flexible nature of our integrated LIFE service (scheme 4 and 28) for reablement and rehabilitation at home and in bedded settings. As the service takes both community and hospital discharge referrals, they are able to flex utilisation and cover gaps as much as possible. However, a few issues have been identified with the data, which is outlined below.

Social support (including VCS) demand and capacity

- Croydon has a very strong VCSE social care offer that is supported through the healthier communities together programme, VCS leadership board and the Localities Commissioning Model, however for the supplied information we have provided in the demand and capacity numbers are for the Personal Independent Coordinators and the Mental Health Personal Independent Coordinators as these are contracted services who supply accurate and timely information.
- The unmet demand for these services has not been able to be calculated for the 2022/23 financial year as the providers do not keep a waiting list and have not been recording instances or unmet demand, hence showing excess in capacity. However, we understand that the services are flexible enough to being able to accommodate variations in demand.
- The above-mentioned recording shortcomings will look to be addressed over the coming year allowing us to be more accurate without forecasting moving forward.

Urgent Community Response

- Reviewing the available data does indicate that demand for Urgent Community Response has steadily increased over the last 12 months. The provided demand and capacity numbers have not assumed that the trend will continue as we do not currently have enough data to test this assumption.
- We have assumed the same demand and capacity numbers, and this is due to the flexible and adaptive nature of the service. The service will move resources as needed to ensure daily demand is met however this may have a knock-on effect to other community teams (e.g. district nursing).

Pathway 1 Reablement and Rehabilitation demand and capacity:

- The Living Independently for Everyone (LIFE) service currently only receive on average 3-4 community cases per day however with the introduction of the Frontrunner programme, we are looking to double the referrals.
- The targeted programme to expand and encourage more uptake by the community teams can be seen in the provided projected numbers within the demand and capacity sheet.
- Currently the ‘additional demand’ in these lines is mitigated through the flexible working of the LIFE team in managing both hospital and community referrals as described above but also by the proactive work of the ICN+ teams (scheme 3) in the community and the new frailty practitioners (scheme 25), as outlined below (frailty).
- We are aware more rehab beds are needed and we have planned for more interim capacity (schemes 73, 77 and 78) this year through the Discharge fund. It has been challenging to commission bed rehab bed capacity due to the nature of the service and the resistance of the market. NHS and LA teams are working to mitigate this and

develop a local offer, but this is likely to be in place from next year. For now, we will have to rely on interim and spot purchased capacity.

Frailty

One of the key areas we continue to invest in through the BCF is around Frailty. The additional frailty practitioner roles and advanced frailty practitioner roles are now in place as of April 2023, following a significant delay due to challenges in recruitment. We therefore anticipate that there will be growing demand from diverting people attending A&E into the LIFE team.

Additional capacity will continue to be provided through Advanced Frailty Practitioners to support the Acute Care of the Elderly (ACE) team to identify and review patients in ED, supporting transfer of care through a frailty SDEC, a virtual ward and into the community as appropriate to avoid admissions wherever possible and support a neighbourhood approach to help frail people to remain as independent as possible. The 'front door' focussed roles will work with the newly appointed ACE Interface Consultant who will focus on early support and intervention for older people in ED and SDEC.

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following 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.**

How BCF funded activity will support delivery of this objective

The provision of proactive care through integrated health and care working (as described above) aims to deliver support to individuals with ambulatory care sensitive conditions (including frailty, falls and LTCs) through the delivery of personalised care plans focussed on:

1) Early identification of need based on risk stratification and clinical review of residents with multiple long-term conditions, experiencing health inequalities, frailty and high use of urgent and emergency care services.
2) Holistic assessment and development of personalised care plans to:
    - Support self-care and access to local community assets
    - Provide support to maintain and, where possible, improve health and wellbeing to reduce reliance on statutory services
    - Ensure plans are in place to support exacerbation of conditions through access to alternative services to urgent care
    - Supporting people to maintain their independence in their own home for as long as possible, reducing or delaying the need for long term care including admission in a care home
    - Supporting people at end of life to die in their place of choice – and at home where possible.
3) Streamlined care, minimising duplication of interventions through MDT working and coordination of care.

4) Review and updating of care plans with the individual at agreed timelines to ensure ongoing shared decision making and personalisation.
5) Better links to Housing and adaptations through the ICN+ MDT process in the neighbourhood model we are implementing.

Changes or new schemes for 2023-25 and impact on metrics

New updated services specifically funded through the BCF to support delivery of these ambitions are:

1. Integrated Community Network Plus MDTs in the community with a focus on developing integrated neighbourhood team approaches in line with the Fuller review (e.g. scheme 3).
2. Proactive Care LCS to be delivered by Primary care to deliver personalised care as part of the ICN+ model of care within neighbourhoods (scheme 21).
3. Frailty practitioners – community and acute (front door) based (scheme 25).
4. Supporting Independence in Croydon – through provision of Personal Independence Coordinators (scheme 10) and Personal Safety / Falls prevention service. (scheme 8) Also a collaborative approach to commission a falls pick-up service through the council's Careline service (scheme 44).
5. New services supporting End of Life patients (Schemes 11-16).
    - Croydon Choose Home provides specialist palliative care support in peoples home during the last days / weeks of life.
    - Advanced Care Plan Facilitator (to commence in June 2023) within the palliative care team, to ensure streamlined and consistent support acute and community settings.
    - Recommissioned End-of-Life night sitting service for 1 year.
    - Recommissioned EOL Carers Respite service from October 2023. This service provides personal care and support for people at end of life enabling carers to take time out from their caring duties. Development of this service specification has been undertaken with input from VCSOs enabling consideration of links with support for carers, and now includes an expectation of supporting carers to identify and access services which meet their needs.

These services will impact on the following metrics.

1) **Unplanned admissions to hospital for chronic ambulatory care sensitive conditions.**
   Croydon has seen an improvement of 12% in this avoidable admission metric from 21-22 to 22-23. As we continue to embed the work undertaken since the implementation of the localities model of care, we are expecting to sustain this performance and to improve it on the back of the new frailty model. As part of that business case, we are assuming a 6% improvement on the 22-23 performance.
2) **Emergency hospital admissions following a fall for people over the age of 65.**
   Croydon has seen an improvement of 6% in emergency admissions due to falls from 21/22 (1048) to 22/23 (985). And an improvement of 15% since 19/20 (1226). Local data suggest we are seeing 985 falls instead of the expected 864 for our population (121 more). As we continue to embed the work and services put in place with the implementation of the localities model of care, we expect performance to align with the expected number of falls on the back of the new frailty model, the services to support the EHCH framework implementation in care homes, and the falls pick up service as part of the UCR model. This will equate to a 12% improvement on the 22-23 performance.
3) **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.**

Croydon has seen an increase in the last 18 months of residents who need long term support in care homes. This has mainly been driven through increased frailty and acuity of residents discharged from hospital through pathway 3. As part of the Frontrunner programme the pathway 3 will be revised with a focus on alternative step-down bedded offer with a focus on the resident returning to their usual place of residence coupled with re-enforcing our home first policy. The step-down bedded offer will include focus on complex social care issues, delirium and non-weight bearing residents. However, we will be seeing a projected increase in 23-24 even with the above measures.

NATIONAL CONDITION 3

Use this section to describe how your area will meet BCF objective 2: provide the right care in the right place at the right time.

Main schemes relating to NC3: Schemes 4, 5, 11, 16, 17, 28, 32, 34, 36, 49, 66, 67, 69, 70, 71, 73, 77, 76, 75, 79.

Please describe the approach to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- **Ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.**
- **How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds**
- **Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.**

Implementing the ministerial priority

This section describes in detail how in Croydon we will align our priorities for health and social care to the national priority to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow.

As this section describes, this will be achieved by embedding strong joint working between the NHS, the local authority and the voluntary, housing and independent sector providers. Over the course of 23-24 and 24-25, a key part of this will be through the delivery of the Frontrunner programme and funding from the hospital discharge fund will be a key enabler to the success of this programme.

Ongoing arrangements to embed a home first approach

A significant proportion of BCF funding is allocated to supporting hospital discharges via the LIFE service, an integrated community-based team comprising staff drawn from across health, social care and the voluntary sector. It provides intensive, proactive and goal-focused

support for up to 6 weeks at times of high levels of need, when individuals require more clinical and social care interventions thereby preventing unnecessary hospital admissions or facilitating early supported discharge from a hospital ward, focussed on enabling the person back to the optimum state of wellbeing, functioning and independence (Reablement, Rehabilitation, Recovery).

The service consists of the following elements:

- Single integrated multidisciplinary Team - A single LIFE Team that brings together existing community services into one integrated, intermediate care, multidisciplinary team.
- D2A pathway which includes a Trusted Assessor model, where Social Care and Therapy staff undertaking a single integrated assessment covering elements of both health and social care. The D2A model is used for all hospital discharges when care and support is required.
- The LIFE service operates 7 days a week, 365 days a year. To support discharges from hospitals, brokerage and social workers have moved to a 6-day coverage (Mon-Sat). This is based on the pattern of discharges during the week, which shows most discharges happening on a Friday.

There is a Home from Hospital service with the Red Cross which supports people who have been discharged from hospital with lower-level care needs, they also offer support within the hospital to ensure all essential provision is in place prior to a home discharge.

Our staff also utilise our community pharmacists who support people at home with their medication following a hospital discharge. They support with any questions people may have regarding new medication prescribed and ensure people are comfortable with what they have been prescribed with support to enable them to be compliant and remain home.

Our LIFE service through the D2A model assesses individuals with a holistic approach collaboratively tapping into all the above-mentioned community services ensuring that patients discharged from hospital are efficiently monitored and onward referred into any of the community interventions.

Funding from the BCF will support the review of all the services ensuring our home first approach for our population is robust, joint up and working collaboratively to deliver more efficiently and cost effectively in the long term. This will include procuring interoperable, end-to-end IT infrastructure for the system.

Supporting a ‘Home First’ approach for people at End of Life

As part of addressing the high proportion of people at end of life dying in hospital, and the overall extended length of stay and delayed discharges for these patients, a number of key services have been developed with the aim of enabling earlier discharge home with support to enable people to die in their place of choice. This includes ensuring that there is a visible and accessible Advance Care Plan (through the embedment of the London Universal Care Plan) which outlines the patients and families wishes and plans to manage exacerbation of needs and imminent end of life.

The aim of the end-of-life pathway for people who have had an acute admission is to:

1. Ensure early review of needs through development / update of advance care plans, completion of Fast Track applications and initiation of community-based support

(including equipment etc) coordinated by an acute Advance Care Plan (ACP) Facilitator (due to commence June 2023)

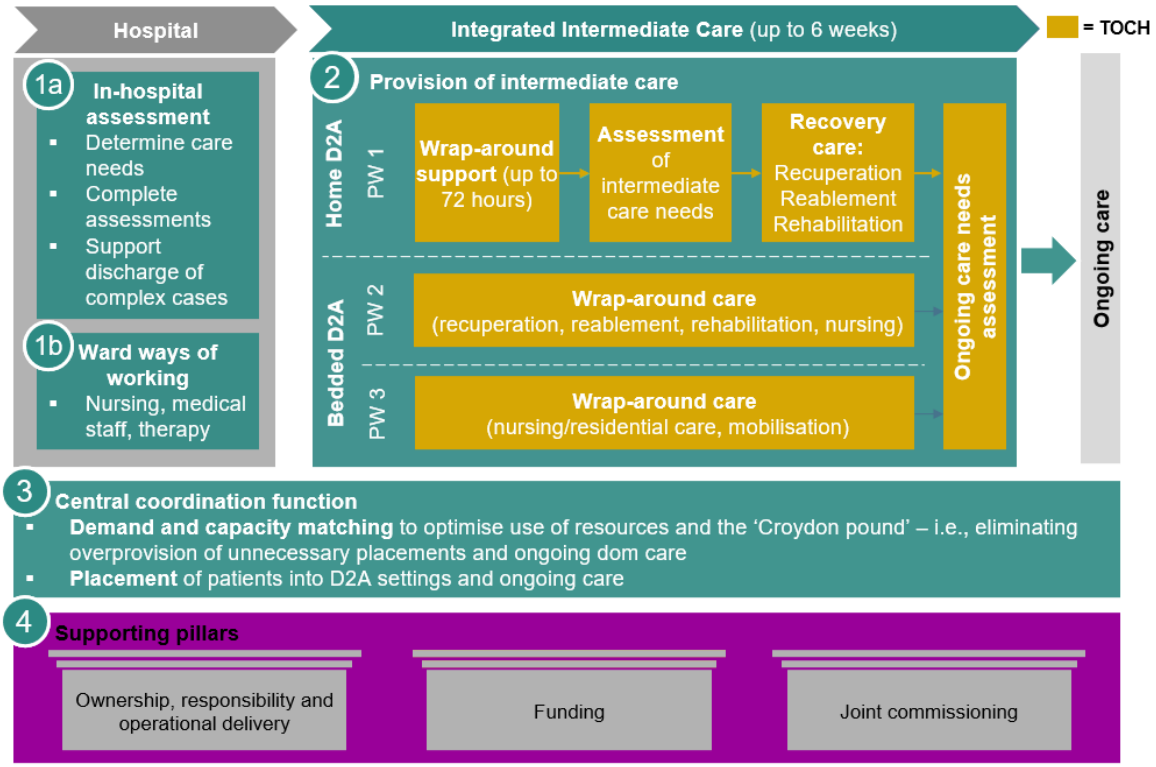
2. provide continuity of seamless care across the acute and community pathways via joint working between the ACP Facilitator and Community Nursing / Hospice / Primary Care / CHC Teams (including through the evolving community integrated model of care and MDT approach)
3. consideration of the need for key services and swift transfer of care to e.g., Choose Home, EOL Night Sitting, EOL Carer Respite, EOL Doula; as well as understanding the non-statutory / Voluntary and Community Sector Services available to provide personalised support which meets the cultural needs of the individual and their carers / family.

How additional discharge funding is being used to deliver capacity to support discharge and free up beds

The additional hospital discharge fund has enabled Croydon to increase the capacity to assess and provide enhanced support to a larger number of discharges – many of which have also shown a rise in complexity.

Discharge funding has increased the capacity in intermediate care provision, enhancing the function in our LIFE team to deliver assessments in the community as well as wrap-around care to keep people safe after discharge. It has also funded addition interim beds (Pathway 3) as well as mental health beds, to ensure people who cannot return immediately home, can be cared for in the community and not in a hospital ward.

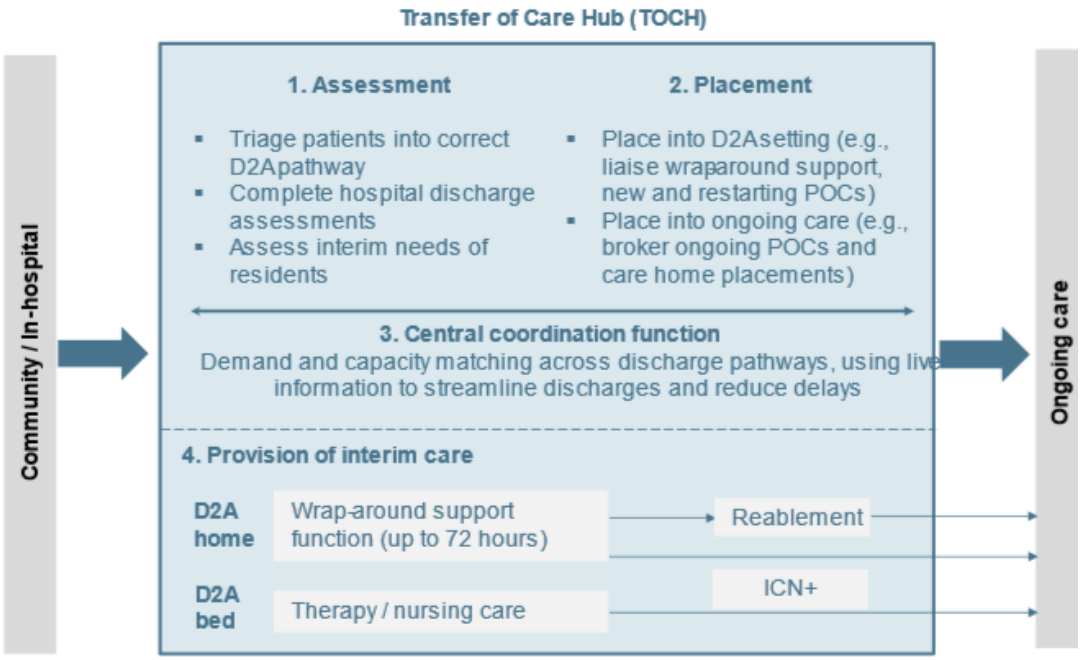
Funding has also been directed to improve local discharge processes, especially around pharmacy support, and for complex discharges of homeless people, which is a significant challenge in Croydon.



Croydon has been selected as one of the six (6) NHSE Frontrunner sites. The high-level aim of the programme is to develop an effective, integrated care provision across the One Croydon Alliance, a collaborative approach across the system. To develop an integrated approach in Croydon, the programme has undertaken a deep dive/ evaluation on all discharge pathways, reablement and Intermediate care offer. This exercise has been done across the system and the key output of the deep dive is to develop an integrated Transfer of Care Hub (TOCH) which will be a fully resourced to include our reablement and rehab offer.

The model will include the following functions:

1. Develop and implement a Transfer of Care Hub (TOCH) One Team, One Budget, One Name - improved interlinks with Primary Care/ ICN+
2. Introducing new blended roles and a flexible budget, this allows the service to use the voluntary sector when required
3. Integrated recovery team that is clinically led, made up of therapy, Health and Wellbeing advisers, reablement workers, pharmacist, personal independence coordinators. (Everyone needing support will get 72 hours of support, before there agreed pathway/ service is decided). The recovery team members will also be a part of the ICN+ GP huddles to ensure complete joint up between primary and secondary care.
4. An integrated commissioning model with joint budget overseen by the joint manager and commissioner.
5. Integrated leadership model to support both strategic and operational development of this new partnership arrangement.



The evaluation also highlighted several areas requiring investment:

- Better IT infrastructure to support information flow between organisations, we are planning to introduce a new integrated platform which will reduce admin time and allow assessment and information to be shared across our IT systems

- All staff both inhouse and external will need to be on the same parr to deliver structured reablement programmes / interventions to ensure effective support for all residents.
- Additional Health and Wellbeing advisors to support the additional daily referral and reduce the LoS
- Additional hours for home care reablement will be required to support the additional referral from hospital and community.

Funding provided via the BCF and the discharge fund will help recruit more inhouse reablement resources, upskill health and wellbeing assessors and support in the procurement of a robust collaborative IT infrastructure that will help with our discharge processes.

Set out the rationale for your estimates of demand and capacity for intermediate care to support people discharged from hospital. This should include:

- **Learning from 2022-23**
    - **Where number of referrals did and did not meet expectations**
    - **Unmet demand**
    - **Patterns of referrals and impact of work to reduce demand on bedded services**
- **Approach to estimating demand, assumptions made and gaps in provision identified**
    - **Where have you estimated there will be a gap between demand and capacity**
    - **How have estimates of capacity and demand been taken on board and reflected in the wider BCF plans**

We have undertaken a deep dive to review our hospital discharge data as part of the Frontrunner programme. This exercise looked at all the discharge pathways, including reablement and intermediate care and were reflected in the demand and capacity analysis and mitigations.

- The system could discharge five (5) more people on to Pathway 1 than what it is currently discharging (10 people)
- Croydon University Hospital ALOS has steadily risen since April 2021, increasing by 16% when compared to pre-pandemic
- Pathway 1 referrals have decreased by 34% since April 2022 – with referrals from the community falling the most
- Of those who start a Package of Care (POC), around 30% are classified as ‘fully re-abled’
- 25% of people referred to pathway 1 come of the service after one week
- A large proportion of LOA is due to delays for people being discharged via Pathway 1&3
- Our Assessment and Triaging function needs transforming in order to help reduce the LOS and ensure our residents are being discharged via the correct pathway.

We aim to move from ten (10) referrals to fifteen (15) discharges on pathway 1, and also aim to reduce the Length of Stay (LoS) for people on pathway three by 5 days. This

transformation will be done through the Transfer of Care Hub (TOCH) which we have designed with mobilisation and implementation due to follow in the summer of 2023. Through the extensive work we have been doing on improving hospital flow and discharge, we will be introducing new blended roles, reducing admin tasks freeing up time to support earlier discharges. We are also introducing a new IT platform connecting the hospital system with the local authority system improving communications and reducing the length of time to organise the discharge arrangements.

All the above has been reflected in the BCF plans (e.g. scheme 75 and 76). A few issues have been identified in the demand and capacity analysis, outlined below.

Social support (including VCS) demand and capacity

Similarly, to the section around community:

- The unmet demand for services has not been able to be quantified for the 2022/23 financial year as the providers do not keep a waiting list and have not been recording instances or unmet demand. Hence the apparent excess capacity. However, we understand that the services are flexible enough to be able to accommodate variations in demand.
- The above-mentioned recording shortcomings will look to be addressed over the coming year allowing us to be more accurate without forecasting moving forward.

Pathway 1 Reablement and Rehabilitation demand and capacity:

- Due to the way the Living Independently for Everyone (LIFE) service is structured and as there is a significant crossover of work taking place within the LIFE team, we are unable to confidently assess the reablement and rehabilitation demand, as the teams work in an integrated way and there are shortcomings in the way referrals are recorded. The two lines should therefore be seen as one service.
- When examining the 22/23 discharge data we can see that there have been an average 15.3 discharges per week, which sets our current demand baseline.
- With the introduction of the Frontrunner programme, we are predicting an increase in both demand and capacity, specifically from Croydon University hospital and mainly through pathway 1, starting from October 2023. This increase in demand and capacity, which can be seen in the predicted numbers, will be the result of additional capacity created via the programme's specific interventions as outlined in this document as well as a predicted decrease in pathway 1 LOS from 17 to 9.7.

Rehab beds (pathway 2)

- We are aware more rehab beds are needed and we have planned for more interim capacity (schemes 73, 77 and 78) this year through the Discharge fund, mostly seasonal. It has been challenging to commission rehab bed capacity due to the nature of the service and the resistance of the market. NHS and LA teams are working to mitigate this and develop a local offer, but this is likely to be in place from next year. For now, we rely on interim and spot purchased capacity as well as additional support for people at home.

Reablement in a bedded setting & Other Short-term social care capacity and demand from the community:

- Croydon place does not have any designated physical reablement beds within a residential or nursing homes, rather these are designated rehabilitation where some reablement may occur.
- Due to the challenges of fitting mental health discharges into the established pathways (SLAM is unable to provide a breakdown by pathway type), it was agreed that the discharges from South London and Maudsley NHS foundation trust into placements would all be recorded as Reablement in a bedded setting. All pathway 3 placements would be considered short term reablement / rehabilitative in nature, and the vast majority of pathway 2 placements are made into new supported living facilities.

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- **Discharge to usual place of residence**

How BCF funded activity will support delivery of this objective

Croydon place has implemented a number of programmes in the last two years that have supported people to be discharged from hospital to their normal place of residence. These include Discharge to Assess, LIFE service, ICN+, Staying Put (housing and adaptations). These programmes will continue to contribute to supporting people discharged back to their normal place of residence.

Enhanced intermediate care capacity has also been created through the Discharge funding and this plan outlines the key areas where this capacity has been created. We are currently reviewing our model for discharges through the Frontrunner programme and one of the key objectives is to increase the number of discharges through pathway 1 by 5 a day.

As part of our reablement development we intend to have a joint commissioned approach with both in-house and external providers. This is likely to be on an agreed process / criteria with all partners e.g., complexity of reablement need to determine the pathway for a person's delivery of the care needed. Further details can be found in the previous sections of this narrative document.

Changes or new schemes for 2023-25 and impact on metrics

Local data is indicating that the percentage of people discharged to their usual place of residence in Croydon has remained approximately stable in 21/22 (93.5%) and 22/23 (93.2%), with only a small deterioration.

A deep dive into our discharge model has shown that we could discharge 5 more people a day, which equates to 390 a quarter and 1560 a year. We also have an additional 156 new people potentially discharged in interim pathway 3 beds in a year.

The high-level aim of the Discharge Integration Frontrunner programme is to develop an effective, integrated care provision across the One Croydon Alliance, a collaborative approach across the system. To develop an integrated approach in Croydon, the programme has undertaken a deep dive on all discharge pathways, reablement and Intermediate care offer. This exercise has been done across the system and the key output of the deep dive is

to develop aa integrated Transfer of Care Hub (TOCH) which will be a fully resourced to include our reablement offer.

The impact of the frontrunner programme will not be felt in full until 24/25, however we can forecast for 23/24 that with seasonality based on the last 2 years the expected discharges and discharges to usual place of residence, take into account the additional activity through the Discharge fund schemes highlighted above and assume a 0.2-0.3% overall improvement to bring us back to the 21/22 performance.

Set out progress in implementing the High Impact change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Impact change	Where are you now?	What do you need to do?
Change 1: Early discharge planning	We have undertaken a deep dive baseline across the system which has identified a lack of proactive discharge planning on wards, partly driven by poor communication at MDTs and unclear discharge roles and responsibilities We are carrying out a pilot on our hospital wards to test new ways of working and a blended model of care approach, based on principles of increased collaboration and communication between teams.	We need to embed the identified changes from the pilot programme as standard operating procedures across all CUH wards and the integrated discharge team We also need a communications strategy which will include our out-of-borough directory of services to help improve comms across our discharge pathways We need to create a training portfolio as well as our competency framework across all pathways to upskill our resources. This is particularly critical for the new 'blended' roles across the system
Change 2: System demand and capacity	Carried out work on our systemwide demand and capacity analysis to ascertain where the gaps are relating to monitoring and meeting demand We have improved our One Croydon system dashboard which highlights demand and capacity for discharge	Need to create a seamless approach to managing the demand through using our current IT systems in enabling us to better monitor the demand to ensure we have the capacity to deliver The development of the TOCH blueprint will require analysis of required capacity within our Transfer of Care Hub
Change 3: Multi-disciplinary working	Carried out a pilot introducing a blended role model of care working alongside the ward-based MDT. This includes Consultants, nurses, therapists, pharmacists, social workers and managers	We need to implement this approach within the hospital and community settings We need to provide the necessary training and competency to upskill our resources and build their confidence We also need to build in our communications strategy to fit in with our wider discharge pathways
Change 4: Home first	System fully signed up to Home First principles. We have introduced a panel who regularly discuss issues relating to complex case	We must intensify our communications of the principles with all various groups and stakeholders who provide care to the people of Croydon Through the Frontrunner programme we are building on our integrated reablement/

	We have created a communications strategy that supports the socialising of the home first principles widely in our system We are also identifying complex patient early in the process to enable effective discharge	intermediate care team to ensure we have the capacity to support more people via D2A The TOCH will have a 'triage' function that will identify the right pathway for patients and will utilise D2A settings (at home and bedded) to assess patients ongoing needs thoroughly in the community. The priority will be to send patients home rather than utilising bedded settings
Change 5: Flexible working patterns	From an Adult Social Care perspective, we have a hybrid working policy which encourages flexible working	We need to ensure we continue to work within the policy and ensure there is a work life balance for all staff
Change 6: Trusted assessment	Majority of our staff e.g., in the LIFE service are trusted assessors in the delivery of equipment, minor adaptations and creating reablement plans We are testing Trusted assessment in the new TOCH being developed – through blended assessors in the integrated discharge team and by reviewing our placement process for nursing/residential homes	Systemwide, we need to be embedding the trusted assessor model through efficient training and development We also need to set up a competency framework for effective delivery for all our residents in Croydon
Change 7: Engagement and choice	We have identified a cohort of people who we need to engage with to provide feedback / experience derived from using our pathways to help with the implementation process We are in the process of identifying stakeholders and community representatives to be part of our programme as a whole Healthwatch are currently conducting a survey to engage with our residents who have been discharged on a D2A pathway 1 to better understand their experiences to help reshape our services going forward	Continue with what we are doing and review the Healthwatch survey findings once completed to support shape the transformation process Device a systemwide Frontrunner communications and engagement strategy to support our mobilisation and implementation We need to continue to engage with all our stakeholders about the benefits of the overall programme – Primary care, carers, staff, residents etc.
Change 8: Improved discharge to care homes	We are currently investigating the gaps / barriers to more timely discharge to care homes from hospital and /or the community We are scoping the potential to have D2A bedded settings (building on the 'winter beds' pilot) that would enable patients to be assessed in the community	We need to be working closely with our commissioners and providers in Croydon to develop our Standard Operating Plans (SOPs) in relation to effective discharge of people into care homes or otherwise
Change 9: Housing and related services	We are seeing a delay in the transfer of care for people with a housing need and related issues	We need to have greater awareness of what is available from a housing perspective and what resources are available for individuals of all ages been discharged from hospital We need to create a SOP for what is available from Croydon council and the wider social housing perspective and how to access this –

		application process, how it is accessed, funding, commissioning arrangements, the pathway for people with Mental Health needs etc.

Please describe how you have used BCF funding, including the iBCF and ASC discharge Fund to ensure the duties under the care act are being delivered.

The Council and health partners fully engaged in deliverable outcomes in 22/23 for the ASCDF and put in various schemes to support flow. These included:

BCF Descriptor	**Work done by Croydon Council with the BCF**
Increasing workforce capacity within the community to allow discharge	BCF in Croydon is used to support posts in A&E, in hospital as well as to support community posts connected to hospital discharge (post discharge assessments). BCF is also used to support a specialist palliative post in Croydon University Hospital.
Increased capacity with home care providers to speed up discharge	Significant use of the BCF in reablement (in Croydon known as the "LIFE" service) to provide reablement packages of care to keep people home, help avoid readmission and help people step down from care altogether over a six-week period.
Increased capacity and costs for support services such as equipment, blitz cleans, keys safes etc.	We use funds from BCF to support our "Staying Put" which helps clients to return home and stay home by facilitating: • Key safes • Deep cleans • Plumbing and electrical work • Repairs (general) • Heating • Furniture moves • Home moves BCF is also used to support specialist telecare which can be for standard items such as falls sensors, but also for more specialist provisions.
Pathway 3 temporary step down beds for residents with complex social care needs	We will be funding beds to support pathway 3 discharge routes and allow clients to recover in a step-down environment.

Mental health step down beds/accommodation	BCF is used to provide POCs and Supported living arrangements which both help to step clients down from acute settings to more independent living.
Discharge hub within the hospital to move residents earlier out of acute beds	This will increasingly become a feature in 23/24. However, we have 1 post dedicated to A&E assessment to help prevent admission and to support people home with a level of support
Supporting SWLICB schemes on step down beds	LBC stepped up several interim winter beds in order to help facilitate faster discharge in winter.

The funding has been announced for 23/24 which must cover the whole of the financial year rather than four months compared to 22/23. The above schemes are in the process of being fully evaluated but from the initial evaluation the following schemes have been identified that have started in the beginning of 23/24 and will be expanded/changed to meet relevant winter pressures:

- Increasing workforce capacity within the community to allow discharge
- Increased capacity with home care providers to speed up discharge
- Pathway 3 temporary step down beds for residents with complex social care needs
- Mental health step down beds/accommodation
- Discharge hub within the hospital to move residents earlier out of acute beds

These schemes will support and complement the work on the transformational hospital discharge ‘Frontrunner Programme’. As detailed within this document the fund where required will support the transformational work in line with the high impact change model.

SUPPORTING UNPAID CARERS

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of care act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Croydon Council commission the Carers Support Partnership to provide carer's assessment and other support services that aim to prevent, reduce and delay future needs for support. The Carers Support Partnership operates on a "hub and spoke" model in which Whitgift Foundation Carers Information Service runs the Carers Support Centre which is the "hub", and specialist services (Croydon Mencap and Mind in Croydon) are the "spokes".

Young carers	537	<15		
	1783	16-24		
			2320	Young Carers
Adult carers	3475	25-34		
	7656	35-49		
	10344	50-64		
	5035	>65		
			26510	Adult Carers >25
	28830	Total all carers		

The BCF contributes 21% (£109,000) to the overall contract value. Services in scope in the current contract include but are not limited to:

- The Carers Support Centre in central Croydon is the hub for carers' support that is easily Accessible
- Information, Advice & Casework – through a range of methods such as telephone helpline, drop-in services, information packs and online directory services.
- Carers Assessment for adults (18+) – carers have the opportunity to talk about their caring role and get the right kind of support they need as a carer i.e., emergency planning, direct payments, respite etc.
- Allocation of carer's direct payment, accessed via the carer assessment
- Respite service – most carers who access this service do not make a financial contribution to their services and therefore the full cost of care would fall to social services. Carers have fed back that having an hour or two break a week is something they can "hold onto" when their caring role becomes challenging.
- Health and wellbeing services such as the Carers Café, training and support groups, exercise classes and creative activities
- Counselling for young and adult carers
- Former carers support includes 1:1 bereavement counselling with a BACP registered counsellor and the Learning from Loss Programme

We do also have a young person's carers service, but not funded through BCF.

The performance of the contract is monitored and reviewed via regular contract monitoring reports and meetings with the service providers to ensure the service meets their targets and

desired outcomes. Performance indicators include a combination of outputs (quantitative measures to assess the volume of activity) and outcomes (determinants of quality and the results achieved) indicators.

Given the reliance on unpaid carers to enable people at end of life to die at home, and support maintenance of dignity and quality of life, Croydon has had an EOL Carer Respite service (funded through the BCF) in place for some time. This service aims to provide personal care and support to the individual at end of life, which would normally be provided by an unpaid carer. This enables the carer to take a break from their caring duties for up to 8 hours per week.

We are currently reprocuring a revised service to commence on 1st October 2023. The revised service specification has been developed based on feedback received, and now includes requirement for an assessment of the need of the carer and signposting to relevant local services. This approach aims to ensure awareness of the range of groups / services available which can provide support to manage the caring duties, provide respite and support to the needs of the carer themselves, but also provide carer / family support after death of a loved one and during bereavement. The adds a personalised approach for the carer based on their needs, as well as those for the person at end of life.

DISABLED FACILITIES GRANT (DFG) AND WIDER SERVICES

What is your strategic approach to using housing support, including DFG funding, that supports independence at home.

The Ministry for Housing, Communities and Local Government allocation for Croydon for 2023-24 is £2,992,679.00. The amount for 2024-25 has not been published yet.

The DFG is a mandatory grant which is subject to a means test. The criteria for this grant are set out in statute. Based on the current average spend of £13,208.84 per adaptation, the original budget could potentially fund 226 adaptations.

Key outcomes are:

- Provide access to suitable adaptations to help people to live as independently as possible in their own homes for longer.
- Allow people to self-manage long term condition(s) rather than rely on other forms of long-term support i.e., personal care using a level access shower rather than washed by care-workers.
- Prevent the need for costly residential placements, by provision of adaptations to help people use essential facilities within their home, move around the home and get into and out of the home.
- Improving safety of the home environment and prevents some unnecessary admissions to hospital or other clinical care settings because of lack of access to facilities in the home.
- People can stay living in their local communities for longer near to their support networks.

The DFG grant in Croydon is delivered under a Private Sector Housing Assistance Policy that is in place. The Policy was updated in July 2021 to reflect the government's guidance for the DFG process to be more flexible in its approach to providing adaptations. As outlined above, in the key outcomes, The Policy is designed to assist 'owner occupiers' to keep homes in good repair, and enable older, vulnerable and people on low income to remain and live independently in their own homes. Our aim is also to provide early interventions to

prevent issues arising that would cost the ICS more money - invest to save. These include Adaptations and supporting Hospital Discharge.

This is in line with the BCF ambitions and is strongly aligned with the strategic work One Croydon is delivering under both the Integrated Community Network Plus programme and more recently that of the Frontrunner programme. It is envisaged that housing for example will be fully embedded with the Transfer of Care Hub we are designing.

Performance of the DFG feeds into BCF Governance Arrangements, the Joint Commissioning Executive and also imports into Croydon's Health and Wellbeing Board. The DFG is monitored monthly, with provision of activity, applications, approvals, timelines, completions and spend. These reports are overseen by the Head of Housing, the Capital Board and Executive Director of Housing.

There are long standing arrangements with the variety of Housing Associations, dependant on their size, on the contributions made to DFG in their properties, the costs agreed in advance and then reimbursed by the Housing Associations, the links and the process works well. As well as adults the DFG covers children with physical, mental and/or cognitive disabilities, which come via Health's Children's OT Service. For the provision of Assistive Technology, it is the OT's responsibility to assess the need of the client and they will make the referral to the Assistive Technology Team to provide the necessary equipment. The split between adults/children is as follows:

- in 2021/2022, 15 cases of disabled occupant 17 years old or less; 67 cases of disabled occupant 18 – 65; 64 cases of disabled occupant 66+
- In 2022/2023, 10 cases of disabled occupant 17 years old or less; 65 cases of disabled occupant 18 – 65; 53 cases of disabled occupant 66+.

We do not currently hold data on the split between physical, mental and cognitive but we are looking at ways this could be recorded in the future.

Croydon's updated Private Sector Housing Assistance Policy, now includes a range of discretionary measures under the DFG to enable a more flexible approach to providing adaptations. A Discretionary DFG, can now be given in addition to the mandatory DFG, totalling £60k. This facilitates major adaptations such as extensions to provide ground floor sleeping and washing facilities OR multiple adaptations through floor lift, Level Access Shower, Step Lift, Ceiling Track Hoists which exceed the current mandatory DFG limit of £30k.

There is an increasing demand for adaptations from Housing Associations. Options are offered to the Housing Associations to enable adaptations for their tenants. One option is to agree that the HIA will project manage the work, and the HA provides a contribution towards the cost of work, or secondly the HA will project manage themselves with funding from the DFG. In 99% of cases, they opt for the HIA to project manage the adaptation work, for which a fee is charged. The larger of the HA's provide 50% funding, or a set amount towards the adaptation.

The DFG and our enhanced reablement services are provided through the in house Staying Put Home Improvement Agency. Our strategy with the enhanced service is to avoid hospital readmission, and to enable people to continue to remain living safely in their own homes, and to increase their independence. We achieve this by providing a range of measures which include fitting key safes, through our Handyperson Service, to enable care packages following discharge. This service also does minor adaptations i.e., grab rails, stair rails, lever taps, fits lockable medicine cabinets, as well as mitigating risks of trip hazards by removing trailing wires, taping torn carpet. We also do blitz cleans, furniture removal to allow micro living, tackle hoarding issues, etc. By providing one or a combination of these measures

enables a safe discharge and independence to the person whilst aiming to avoid hospital readmission.

ADDITIONAL INFORMATION NON-ASSURED

Have you made use of the Regulatory Reform (Housing Assistance) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

YES

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

There is no set amount allocated for discretionary use, as the mandatory DFG limit is £30k a large proportion of the adaptations carried out exceed this amount and require us to use discretion to 'top up' these grants. This is in part due to the general increase in the cost of materials and equipment and labour costs.

Following approval of the Discretionary measures approved in the PSHA Policy in 2021, we are currently awaiting Cabinet approval to amend the Discretionary Disabled Loan Conditions.

This will assist disabled households where there is a working adult, who under the current means test for Mandatory DFG would not be eligible for any assistance with adaptations.

We undertake a preliminary financial assessment at an early stage, to determine grant eligibility, to avoid people being on a waiting list unnecessarily, who would not get any grant assistance with adaptations. Our records show that there is an increasing number of people who fall into this category, who we could potentially assist.to enable independence at home. OBJ

EQUALITY AND HEALTH INEQUALITIES

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include:

- **Changes from previous BCF plan**
- **How equality impacts of the local BCF plans have been considered**
- **How these inequalities are being addressed through the BCF plan and BCF funded services**
- **Changes to local priorities related to health inequality and equality and how activities in the document will address these**
- **Any actions moving forward that can contribute to reducing these differences in Outcomes**
- **How priorities and operational guidelines regarding health inequalities as well as local authorities' priorities under the Equality Act and NHS actions in line with the Core 20Plus5.**

Changes from previous BCF plan

One Croydon and the residents we serve experience unique challenges. As a community, we also share many strengths that contribute to our success. Croydon has the largest population of all London boroughs, with approximately 390,800 residents (ONS Census

2021). We are incredibly diverse—both geographically and in terms of socioeconomic make up.

- 50% of the South West London's Core20 population live in Croydon. Croydon, patients categorised as Core20+5 actually represent 40% of our population.
- Of the more than 33,000 carers in Croydon, 65% provide up to 19 hours of unpaid care a week; 20% provide 50 hours or more. This is being address through the development of a carer's strategy and commitment to support unpaid carers.
- There are over 2,000 homeless households in Croydon per quarter—a number that has remained consistent for many years. Individuals who identify as Black are represented at a much higher proportion within this demographic than those from other communities. This is being address through the implementation of a homeless discharge pathway.
- Excess weight in primary school pupils remains a national concern; 38% of Croydon pupils in Year 6 have excess weight (rolling three-year average to 2019/2020). This is being address through the implementation of weight management programmes.
- A significant number of people with Diabetes and CVD, a large proportion of people with hypertension who are undiagnosed, and inequality of access to respiratory diagnostics for Asthma and COPD. These are being addressed through funding services to support diagnosis and management of these LTC.

Croydon continues to face similar challenges as in previous years around health inequalities. The difference is how these challenges are addressed, through embedding on tackling health inequalities in every programme. The Core20+5 approach has enabled detailed analytical research across South West London Integrated Care System to examine our patient demographic. Primary Care Networks are also addressing many issues around health inequalities using population health management and as part of the delivery of the PCN DES.

These priorities regarding health inequalities are in line with the Core 20+5, as outlined in the sections below.

How equality impacts of the local BCF plans have been considered

For new services, Equality Impact Assessments will be carried out to assess impacts on protected groups.

A Health Inequalities Outcomes Framework (HIOF) is currently being developed in partnership with Croydon Public Health Team to enable the monitoring of health inequalities at a local level. The HIOF will use the following key outcomes:

- Gaps in life expectancy
- Gaps in healthy life expectancy
- Gaps in the top two conditions contributing to early death in Croydon (cancer and cardiovascular disease)
- Gaps in the top two conditions responsible for ill health in Croydon (mental illness and musculoskeletal disease)

Indicators related to these four key outcomes will be selected from the evidence base around the key factors across the life course that contribute to health inequalities observed in these outcomes. Where data permit, the Framework will aim to monitor gaps by different equalities groups including age, sex, ethnicity as well as locality and area-level deprivation.

The HIOF will aim to support:

- Identification of key risk factors that contribute to health inequalities in different stages of life including childhood and adulthood.
- Early and appropriate action across the life course to protect and promote health.

It is envisaged that the HIOF will:

- Inform long-term strategic planning and decision making for One Croydon's most senior decision makers
- Support local delivery plans so that they can better target health inequalities within certain groups or geographies

Changes to local priorities related to health inequality and equality and how activities in the document will address these

Health Inequality Funding

In September 2022, SWL informed place partnerships that funding could be made available towards each place Health Inequalities strategy to address the CORE20+5 focus areas as part of the wider SWL Health Inequalities framework. The following projects were selected and are being implemented:

- Healthier Lifestyles Health Hubs
- Children and Young People Tier 3 Weight Management
- Adult Tier 3 Weight Management
- Expert Patients Programme Expansion
- EMHIP – Mobile Mental Health and Wellbeing Hub
- Health Innovation Projects to support in tackling inequalities

How these inequalities are being addressed through the BCF plan and BCF funded services

Croydon have enhanced community services in place across Long Term Conditions to tackle and address Health Inequalities. Below are a few examples of programmes that will be funded through the Better Care Fund either in full or in part. Areas include Diabetes, Homelessness and other key CORE20+5 groups. It is worth noting that given the significant level of health inequalities experienced in Croydon as highlighted in the Core20+5 analysis most programmes have been refocused to support addressing inequalities, monitoring impact on the Core20+5 populations, as well as meeting statutory requirements from the Equality Act.

1) Homeless and Rough sleepers' pathway to tackle Health Inequalities (BCF funded)

Croydon, is seeing an increase in the number of rough-sleepers at 3x the rate compared to the rest of London. Homeless communities have complex needs which results in a bleak health inequity as is reflected in the average age of death amongst people who are homeless - 43y (female) and 47y (male), versus 83y (female) and 79y (male) for the general population. Using Adult Social Care Discharge funding we are looking to implement a specialized hospital in reach service (called Pathway) for homeless community to improve outcomes for this vulnerable community. The aims of the local Homeless Pathway service include:

- Improved identification of homeless patients within the hospital
- Holistic health, care and discharge planning for homeless patients
- Safe and effective discharge from hospital for service users
- Improved collaborative working by hosting multidisciplinary team meetings (MDT).

2) Integrated Diabetes Service (BCF Funded)

26,000 adults registered with a Croydon GP now have diagnosed diabetes. The CORE20 population has higher rates of diabetes than the general population: The average CORE20 member in South West London is:

- 34/% more likely to be diagnosed with diabetes
- Are diagnosed on average 4 years younger (at the average age of 61)
- 10% less likely to be achieving their diabetes treatment targets (which lowers the risks of complications)

The principal aim of the Croydon diabetes model of care is to ensure that services become integrated across the system. The focus of the Integrated Diabetes Service is on the prevention or delay in the development of complications by Improving the management of diabetes within primary care and reducing variation through joint working and upskilling.

Any actions moving forward that can contribute to reducing these differences in Outcomes

1) Healthier Communities Together Programme

Now in its second year of delivery, the Healthy Communities Together programme is going from strength to strength as it harnesses the skills of local people to create preventative health and social care services for residents. Building on the work established by Croydon's voluntary and community groups and by harnessing their skills and local expertise, communities have been empowered to take an active role in their neighbourhood to develop solutions to meet some of the wellbeing needs in their area.

Understanding the importance of a need to transition towards a proactive and preventative care model and build on the strengths of local people, a Local Community Partnership (LCP) has been created in each locality to bring greater local ownership, a collective voice and leadership that is representative of the local area.

Seeing residents as assets with rich, local knowledge and inspirational creativity, residents attend locality-based meetings along with community groups, local charities and health and social care teams to co-develop practical action plans to address each locality's health inequalities through locally co-ordinated activities and services.

These open forums provide the opportunity for residents, community groups, local charities and health and social care teams to co-produce community action plans and work collaborative to put these into action.

Croydon have applied loads of resource and assets to support Health and Social Care partnerships in joining up some of the services where applicable, and utilising contacts and memberships across those services to ensure there is limited duplication.

2) Population Health Management – Optum Scheme

Croydon commissioned a population health management strategy to identify people with hypertension in the lowest areas of deprivation across the localities. The delivery plan is currently being implemented using insights and development of traditional and non-traditional methods to integrate the service with Primary Care Networks and VCSE organisations in Croydon.