Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, 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 (DLUHC), 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) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
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 Health and Wellbeing Boards (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 ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

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 and those that are not for completion are in grey, as below:

Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

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 to 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.

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 submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
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 HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (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/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB 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: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the locally set ambitions 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 in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly 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 Better Care Exchange) 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:	Jack Edge	
E-mail:	Jack.edge@swlondon.nhs.uk	
Contact number:	020 7360 9326	
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 report is expected to be signed off:	Wed 20/12/2023	<< Please enter using the format, DD/MM/YYYY

Checklist	Complete:
	Yes
	Yes
	Yes
	Yes
	Yes
	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 Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Croydon

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	

Confirmation of National Conditions			
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**	**Checklist** Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Croydon

National data may be unavailable at the time of reporting. As such, please use 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 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	154.0	132.0	165.0	150.0	165.9	Not on track to meet target	There are a number of challenges that the local system is facing, including workforce shortages, impact of strike action and exacerbation of long term conditions. We are aware these are national problems and not just for Croydon, but it is difficult to recruit to new posts at the moment - this in turn is causing a delay to the implementation of new projects or improvement schemes. The frailty frontdoor model for example has been delayed significantly due to delays in recruitment and the model is not fully functional yet as there are gaps in the community posts still.	Proactive care model in Croydon – The approach for proactive care in Croydon, which aims to support early holistic assessment and personalised care with residents with multiple LTCs and using / or at risk of using urgent and emergency care services (including health inequalities related needs) is currently being further developed. This builds upon the approach to integrated team working wrapped around patients and general practice in a neighbourhood team with support provided for complex needs as well as signposting to services for self care / self management to minimise over medicalising wider needs. Work is in progress to revise current primary care contractual arrangements for delivery of this approach including development of system wide measures to support clear demonstration in the change in ED usage and admissions. Along side this work, we have also commenced engagement with general practice to understand how we can further shape the approach to MDT working, based upon the principles of Integrated Neighbourhood Teams outlined in the Fuller	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.5%	93.6%	93.3%	93.1%	92.80%	On track to meet target	There are still some challenges in gathering local data to understand the flow through the different discharge pathways. Work is underway to review D2A across the whole system and to ensure people are put on the right discharge pathway.	The latest figure (June 2023) is 94.1% and local intelligence suggests we are on track to meet the target having achieved 93.5% in Q1. This is somewhat different from the national reported performance but there is an increasing trend from 92.8% ini April 23 to 93.4% ini May 23 and 94.1% in June 23, which is positive. As part of frontrunner programme to improve hopsital discharges, we are implementing the follow: • A new health led 'wraparound' care service to receive patients upon discharge home from hospital and to provide up to 7 days of recuperation/care before holistically assessing their intermediate care needs • Prototyped the new health led 'wraparound' care service to test different models of the service (e.g., internal staff vs agency staff) • Worked with hospital ward teams to introduce nursing-led morning board rounds leading to higher quality discussions and discharge planning There are some delays in the implementation of the model but we are confident the impact will start to be be felt through winter.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,607.0	491.2	On track to meet target	There are a number of challenges that the local system is facing, including workforce shortages, impact of strike action and exacerbation of long term conditions. We are aware these are national problems and not just for Croydon, but it is difficult to recruit to new posts at the moment - this in turn is causing a delay to the implementation of new projects or improvement schemes. The frailty frontdoor model for example has been delayed significantly due to delays in recruitment and the model is not fully functional yet as there are gaps in the community posts still.	Local data has shown that emergency admissions due to falls has decreased compared to prepandemic numbers (308 in Q1 2019/20 vs 233 in Q1 2023/24). For the same quarter, the numbers are decreasing every year. BCF funds Community Falls team and well as supporting independence services and home modifications in the DFG programme. A review of falls services is planned as part of the local implementation of the SWL ICB Frailty model this includes: o Development of an innovative post falls vision pathway – working with local optometrists and AgeUK Croydon to ensure that residents are able to access enhanced vision tests following a fall. This is in addition to a repeated standard vision test already available – with the aim of testing wider vision fields than currently available. The aim is to test the pathway, in order to support early identification of vision defects which may be addressed in primary care by optometrists, through referral to community vision services or highlight other needs. Referral through AgeUK existing services (including falls prevention) supports	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				540		On track to meet target	There continues to be a high number of permanent admissions into residential care either from Discharge To Assess or community referrals. Whilst partners follow the home first principals there is a number of residents with high acuity needs.	Whilst the numbers are still high we have had the following successes through the use of the Adult Social Care Discharge Fund 1) Increase number of social workers in hospital to support Home First policy 2) 11 step down beds to come online from 1 October 2023 to support 28 day step down back home to focus on social care needs. 3) A clear tracking system out of hospital to support residents getting to their long term care destination and focusing on independence and long term care.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				96.0%		Not on track to meet target	There is still a high number of discharges from hoispital on pathway 1 and people with high acuity needs coming into the reablement services which is putting pressures on community services to reablle.	Croydon has been selected as a national pilot under the Frontrunner programme. It has trialled a prototype Wraparound/recovery 7 day service so residents get early intervention from all relevant services and daily community MDTS which will be extended further into September and October. The Council has also launched a triage team to support on ensuring good quality referrals being sent to the relevant pathways to help ensure that the right care is in place at point of discharge.	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections?	
The vast majority of our original demand and capacity estimates have undergone no significant changes. The differences seen within 5.2 and 5.3 of this document are within the original margins of error that was applied and therefore have remained unchanged. We believe that the formulas to calculate the demand and capacity are based on sound fundamentals which in themselves did not have to be changed for this revision exercise.	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?)	
Demand:	
Regarding Pathway 1, the programme team initial predicted that with the introduction of the Frontrunner programme we would see an increase in demand, specifically from Croydon University hospital and mainly through pathway 1, starting from October 2023. As stated above this change did not take place and as such we have revised the demand figures from October to revert back to the original formula that was used to predict the first 6 months demand.	Yes
Capacity:	
As with the pathway 1 demand statement above, Croydon place was expecting to see an increase in capacity, specifically from Croydon University hospital and mainly through pathway 1, starting from October 2023. Once again this change did not take place and as such, we have revised the demand figures from October to revert back to the original formula that was used to predict the first 6 months demand.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan?	
Croydon place has an ongoing programme of looking at different interventions that would either increase capacity or lower demand, most of these interventions have been scoped out within the original BCF demand and capacity estimates and have been accounted for within the original figures.	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
Croydon Place is currently finding that capacity to deliver is being stretched with additional reporting and governance requirements .i.e. fortnightly discharge report and BCF reporting. Furthermore workforce vacancies and sickness is a concern, especially in general practice and LIFE (D2A) team. This coupled with a lack of winter funding for primary care have raised some concerns for the winter ahead.	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data).	
There are some minor data quality concerns however all of the concerns can be mitigated with triangulated data. Ongoing work is underway to improve the data quality used.	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
Currently Croydon Place is not expecting any demand to exceed capacity, as this point.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of 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) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, 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 Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy 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.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected 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 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. 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 these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. 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 Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy 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."

Complete:

Better Care Fund 2023-24 Capacity & Demand Refrresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

Hospital Discharge

Capacity - Demand (positive is Surplus)	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	-1	8	0	5	9	-1	8	0	5	9	-1	8	0	5	9
Reablement & Rehabilitation at home (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	98	98	99	98	99	-5	-5	-4	-5	-4	-5	-5	-4	-5	-4
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	0	0	6	5	6	6	6	6	6	6	6	6	6	6	6

Capacity - Hospital Discharge

Service Area	Metric	Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing					Checklist
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Complete:
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	50	50	50	50	50	50	50	50	50	50	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	589	589	596	590	609	386	346	356	356	363	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	122	123	125	123	125	122	123	125	123	125	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	0	0	14	13	14	14	14	14	14	14	0	0	0	0	0	Yes

Demand - Hospital Discharge

Pathway	Trust Referral Source	Prepopulated from plan:					Please enter refreshed expected no. of referrals:					Checklist
		Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	
Social support (including VCS) (pathway 0)	**Total**	**51**	**42**	**50**	**45**	**41**	**51**	**42**	**50**	**45**	**41**	
	CROYDON HEALTH SERVICES NHS TRUST	51	42	50	45	41	51	42	50	45	41	Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
	(blank)											Yes
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Reablement & Rehabilitation at home (pathway 1)	**Total**	**589**	**589**	**596**	**590**	**609**	**386**	**346**	**356**	**356**	**363**	Yes
	CROYDON HEALTH SERVICES NHS TRUST	377	377	381	377	390	247	221	228	228	232	Yes
	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	24	24	24	24	24	15	14	14	14	14	Yes
	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	47	47	48	47	49	31	27	28	28	29	Yes
	OTHER	82	82	83	83	85	54	49	50	50	51	Yes
	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	59	59	60	59	61	39	35	36	36	37	Yes
	(blank)											Yes
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Short term domiciliary care (pathway 1)	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**24**	**25**	**26**	**25**	**26**	**127**	**128**	**129**	**128**	**129**	Yes
	CROYDON HEALTH SERVICES NHS TRUST	19	20	21	20	21	19	20	21	20	21	Yes
	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	1	1	1	1	1	104	104	104	104	104	Yes
	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	Yes
	OTHER	2	2	2	2	2	2	2	2	2	2	Yes
	ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	1	1	1	1	1	1	1	1	1	Yes
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**0**	**0**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	Yes
	CROYDON HEALTH SERVICES NHS TRUST	0	0	8	8	8	8	8	8	8	8	Yes
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Croydon

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	4	4	4	4	4	4	4	4	4	4
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting	-4	-4	-4	-4	-4	0	0	0	0	0
Other short-term social care	2	2	2	2	2	2	2	2	2	2

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:				
Service Area	**Metric**	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	81	81	81	81	81	81	81	81	81	81
Urgent Community Response	Monthly capacity. Number of new clients.	362	468	374	381	406	416	538	430	438	467
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	135	135	135	134	135	89	89	89	89	89
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	4	4	4	4	4
Other short-term social care	Monthly capacity. Number of new clients.	2	2	2	2	2	2	2	2	2	2

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	77	77	77	77	77	77	77	77	77	77
Urgent Community Response	362	468	374	381	406	416	538	430	438	467
Reablement & Rehabilitation at home	135	135	135	134	135	89	89	89	89	89
Reablement & Rehabilitation in a bedded setting	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

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes