Place Board Incorporating the Health and Wellbeing Board

DATE	23rd September 2022
REPORT OF	Councillor Stan Shreeve Portfolio Holder for Health, Wellbeing and Adult Social Care
RESPONSIBLE OFFICER	Simon Galczynski, director of adult services
SUBJECT	Better Care Fund (BCF)
STATUS	Open
FORWARD PLAN REF NO.	N/A

CONTRIBUTION TO OUR AIMS

The continued receipt of BCF monies contributes to the aims of stronger economy and stronger communities

EXECUTIVE SUMMARY

The Better Care Fund (BCF) is designed to promote integration between health and social care, and to create a local single pooled budget to incentivise the NHS and local government to work more closely together. BCF has not been the driver for integration in North East Lincolnshire (NEL), where an agreement under s75 of the NHS Act 2006, and pooled budget arrangements, have been in place since 2007.

Each area is required to produce a BCF plan annually, evidencing its progress towards integration since the last plan, and its focus during the coming year. Plans are expected to be a continuation of previous plans, and must be produced in accordance with each year's BCF guidance issued by the Department of Health and Social Care (DHSC) and NHS England (NHSE).

This report attaches the plan relating to 1st April 2022 to 31st March 2023, for approval. The plan comprises three documents, in templates provided by NHSE:

- A narrative plan (word document)
- A planning template (spreadsheet)
- A capacity and demand plan (spreadsheet).

RECOMMENDATIONS

1. Approve the plan for national submission to NHSE on 26th September 2022
2. Delegate authority to the Director of Adult Services and ICB (Integrated Care Board) representative in consultation with the Portfolio Holder for Health, Wellbeing and Adult Social Care, to amend the plan, if required by NHSE to secure its approval, and thereafter submit.

REASONS FOR DECISION

It is a requirement of the BCF that local plans are agreed by Health and Wellbeing Boards.

1. BACKGROUND AND ISSUES

1.1 Delayed receipt of BCF requirements

The BCF conditions for the year 2022/23 were not made available until July 2022. Areas were asked to submit their plans for informal feedback, for the year 2022/23, within four weeks from receipt of conditions. Informal feedback on the draft narrative plan and draft planning template was received on 1st September from the regional BCF team, and plans were revised in response to it. The documents attached to this report comprise those plans in revised form, for national submission. In addition, there is a new requirement this year to submit a capacity and demand plan, which is also attached to this report.

As the year to which the plan relates was already past its first quarter when notification to complete the plan was received, the plan brings up to date the first quarter of activity, and sets out intentions for the remainder of the year.

National approval of plans is not expected before 30th November 2022.

1.2 National conditions

This year's national conditions are:

1.2.1 Plans jointly agreed between local health and social care commissioners and signed off by the Health and Wellbeing Board

1.2.2 NHS contribution to adult social care to be maintained in line with the uplift to NHS Minimum Contribution

1.2.3 Invest in NHS-commissioned out-of-hospital services

1.2.4 Implement BCF policy objectives. The policy objectives are:

1.2.4.1 Enable people to stay well, safe and independent at home for longer

1.2.4.2 Provide the right care in the right place at the right time.

There is a change to this year's requirements when compared with previous years. This year, two policy objectives have been added (at 1.2.4 above). These objectives may be considered to have been implicit in previous years, but have been made explicit this year. The objectives are already part of NEL's Adult Strategy, and developing Health and Care Strategy, both of which are referenced in the plan.

The attached narrative plan and planning template are intended to confirm that the national conditions are met.

1.3 National Metrics

The metrics are:

1.3.1 proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement)

1.3.2 older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)

1.3.3 unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital)

1.3.4 improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of

residence).

There is a change to this year's metrics when compared with previous years. The length of stay metric has been removed, and there is an increased requirement for narrative confirming the rationale for metric ambitions.

The attached planning template is intended to set out how metric ambitions have been set, and how they will be met for the remainder of the year.

1.4 Capacity and demand plan

This plan is a new requirement, intended to collect information on capacity and demand for intermediate care. This plan is not a moderated part of the overall plan, but must still be submitted alongside the narrative plan and planning template. The plan has presented some challenges in that:

1.4.1 part of the data on which it is based is derived from Northern Lincolnshire and Goole Hospitals NHS Foundation Trust level data, which includes activity outside of NEL. Proportional adjustments have been made to this data to more accurately reflect the position in NEL only, based on the current year's activity

1.4.2 the definition of 'intermediate care' is a very broad one (roughly relating to re-abling services which prevent hospital admission or help post discharge). To ensure that the plan is manageable and focused, services with more general community preventative functions (for example, telecare) have been excluded. Further guidance on definitions has been requested of NHSE within the plan, for reference in future years.

1.5 Agreed spend

The BCF requires Integrated Care Boards (ICBs) to continue to pool a mandated minimum amount of funding, and local authorities to continue to pool grant funding from the iBCF, winter pressures funding and the Disabled Facilities Grant (paid directly by government to the Council). Summary Finance information is provided below and shows the relative split of the 2022/23 £25.3m pooled fund:

Funding received by	BCF element	Revenue or capital	Allocation 22/23 £'000	Planned Expenditure £'000	Planned Variance £'000
NELC	Disabled facilities Grant (DFG)	Capital	3,221	3,221	0
NEL ICB	ICB contribution *	Revenue	13,994	13,994	0
NELC	IBCF	Revenue	8,059	8,059	0
Total			**25,274**	**25,274**	**0**

* £5.1m of the ICB contribution is directed to support adult social care and is managed within the adult social care s75 budget envelope. In addition, the £8.1m iBCF (improved better care fund) is used by the council to support adult social care services.

The way in which BCF monies are utilised for the period 1st April 2022 to 31st March 2023is set out within the attached planning template.

2. RISKS AND OPPORTUNITIES

2.1 There is some risk that the metrics will not be met. Rationale for metrics targets is offered within the attached template. Whilst it is always possible that metric targets will not be met due to unforeseen circumstances, there is some additional risk connected with the avoidable admissions target. This relates to the way in which admissions are recorded. This recording issue is a national one, which local systems are aware of and are monitoring.

2.2 Progress on delivery of the disabled facilities grant (DFG) programme has remained challenging due to increased demand post Covid and shortages in applicants for key roles, including back office operational resource and specialist occupational therapy input. Four additional building surveyors have been successfully employed, which has contributed to improved productivity. Monthly performance monitoring of the entire DFG process has now been established, tracking performance activity from the first call into the service to completion of works, which is supported by a revised DFG process map.

2.3 Integrated working continues to provide opportunities to work more efficiently and effectively for the benefit of the place of North East Lincolnshire.

3. OTHER OPTIONS CONSIDERED

N/a. Submission of a plan/ confirmation of compliance with conditions is nationally mandated.

4. REPUTATION AND COMMUNICATIONS CONSIDERATIONS

The area would be likely to suffer some reputational damage if national requirements were not met.

Planning in the areas to which BCF relates or is linked are heavily reliant upon partnerships within and outside of the ICB and council, and high levels of cooperation and communication. All BCF plans to date have been published on the CCG's website (as it was then). Following approval of the current year's plan, it too will be published online.

5. FINANCIAL CONSIDERATIONS

Financial considerations are considered within the main body of the report above. The current s75 agreement between the council and ICB provides the mechanism for pooling resources and for sharing risks.

6. CHILDREN AND YOUNG PEOPLE IMPLICATIONS

The focus of the BCF is on adult services. There are no known implications arising from this report, for children and young people.

7. CLIMATE CHANGE AND ENVIRONMENTAL IMPLICATIONS

There are no known climate change or environmental implications arising from the matters in this report

8. CONSULTATION WITH SCRUTINY

No consultation with Scrutiny or otherwise has taken place.

9. FINANCIAL IMPLICATIONS

There are no direct financial implications as a result of this report, which outlines spend for inclusion within a national return. Spend against budgets and utilisation of available funding is reported as part of the Council's regular budget monitoring processes and through reports to Cabinet.

10. LEGAL IMPLICATIONS

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. The amended NHS Act 2006 gives NHSE powers to attach conditions to the payment of the BCF, and to withhold, recover or direct the use of funding where conditions attached to the BCF are not met Compliance with BCF annual and quarterly reporting regime is mandatory.

11. HUMAN RESOURCES IMPLICATIONS

There are no HR implications.

12. WARD IMPLICATIONS

There are no known individual ward implications. BCF monies are spent for the benefit of NEL as a whole.

13. BACKGROUND PAPERS

N/A

14. CONTACT OFFICER(S)

Simon Galczynski (simon.galczynski@nhs.net) and Emma Overton (emmaoverton@nhs.net).

Councillor Stan Shreeve, Portfolio Holder for Health, Wellbeing and Adult Social Care

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Health and Wellbeing Board(s)

North East Lincolnshire

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

In addition to sharing the draft plan with key individuals across health, care and housing (including DFG), the plan has also been shared with:

- Health Care Partnership (HCP) leadership group, comprising
  - *Care Plus Group*
  - *Core Care Links (GP out of hours)*
  - *Focus Independent Adult Social Work*
  - *Navigo*
  - *NLaG NHS Foundation Trust*
  - *North East Lincolnshire Council*
  - *North East Lincolnshire Partnership Foundation Trust*
  - *Primary Care Networks (PCNs)*
  - *St Andrew's Hospice*
  - *St Hugh's Hospital*
  - *VCSE (voluntary, community and social enterprise sector)*
- Centre4
- Sector Support North East Lincolnshire Partnership
- Healthwatch.

How have you gone about involving these stakeholders?

The BCF plan is reflective of the Adult Strategy, noted in the previous plan. This Strategy was developed in 2018/19 following an adult services review, which involved significant engagement across key health, care and voluntary sector partners. Progress against Adult Strategy objectives is being reviewed as it nears the end of its life (2022) with involvement from key health, care and voluntary sector partners (for example via 'appreciative inquiry' style interviews and an online survey).

It is likely that the Adult Strategy will be replaced by the Health Care Partnership (HCP) Strategy. To date, the HCP Strategy has been the subject of discussion at the CCG's Community Forum and ACCORD Steering Group (prior to 1st July) and at an engagement event with voluntary sector partners, as well as discussion with the HCP partners. These discussions, and the development of the HCP Strategy, are/ is ongoing. The HCP Strategy will aim to align with BCF plans.

Due to the very tight timeline within which a BCF plan must be created, genuine involvement in the BCF plan itself is limited. However, in having input into the Adult Strategy (and its current review) and creation of the HCP Strategy, partners have in effect been involved in development of the BCF plan. The BCF plan has been shared in draft form for comment.

Executive summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

North East Lincolnshire's (NEL) approach to health and wellbeing, focusing on prevention, putting the community at the centre of service re-design, and supporting people to take more responsibility for their wellbeing, is represented in the 'funnel of transformation' depicted in previous BCF plans (the revised funnel also features on page 19 of this plan). This focus on community-based prevention remains key to current and future planning.

The Adult Strategy (applicable to all adult health and care services) referenced in our 2019/20 plan continues to set out our person-centred, enabling, approach. By focusing on individual and community assets, we aim to increase the likelihood that we will create a resilient population able to thrive on independence and self-care, and reach their maximum potential. The priorities set out in the Strategy continue until the end of year, although it has not been possible to progress in all areas at the speed, or in exactly the same way as, envisaged before the pandemic. Delivery of Strategy aspirations remains challenging due its ongoing impact.

The Adult Strategy is likely to be replaced by a Health Care Partnership (HCP) Strategy currently in development. The HCP Strategy will set out similar objectives in terms of promoting population health and independence, as described in the Adult Strategy and our previous BCF plan(s). The HCP Strategy will be signed off by the NEL Health and Care Joint Committee. This committee comprises representatives of the Council, HCP and ICB (Integrated Care Board), and has been created since submission of our previous plan. The Committee will have oversight of delivery of the HCP Strategy. The HCP Strategy will be implemented by the HCP.

Governance

As noted in our previous plans, individual schemes are generally subject to monitoring and/ or are monitored by a scheme board or steering group, comprising professionals and community members. This means evaluation is on-going as part of 'business as usual', rather than a one-off activity for the benefit of our BCF plan. Any underperformance is addressed via the relevant board/ steering group or contract monitoring meetings.

BCF governance is part of overall partnership governance set out in the s75 agreement, updated to reflect the move from CCG to ICB. The pooled budget manager is the ICB's Place Director for Finance (South Bank) and the Council's Director of Resources and Governance. The overall lead for the plan is the director of adult services. The plan is developed jointly by Council and ICB. On-going high-level oversight of BCF schemes, and development of BCF plans, is undertaken by the BCF steering group (comprising ICB and Council staff), reporting to the Health and Care Joint Committee. The Committee in turn reports to the Health and Wellbeing Board.

SIGN OFF OF PLAN: the draft plan was supported in principle by the Joint Committee on 24th August 2022. At that time, it was awaiting regional comments. The final plan was signed off by the Health and Wellbeing Board on 23rd September 2022.

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

Overall BCF plan and approach to integration

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

a) Joint priorities for 2022-23
b) Approaches to joint/collaborative commissioning
c) How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

a) Joint Priorities

This section of the plan sets out priorities and notes relevant changes when compared with narrative offered in previous BCF plans.

The Adult Strategy sets out how the ambitions of the local outcomes framework, and how the place-based vision for health and wellbeing (also referenced in our previous BCF plans), can be delivered by adult services. This year the ambitions in the Adult Strategy are being revisited, and are likely to appear in the developing HCP Strategy in revised form. At present, the below priorities remain pertinent and have been updated as relevant.

i. Information and advice and the Single Point of Access (SPA)

LiveWell

The LiveWell site (launched on 31st March 2021 - https://livewell.nelincs.gov.uk/) - which replaced Services4Me, continues to act as our single point of information (referenced in our previous plan). This enables professionals and local people to access low level support to help themselves. LiveWell includes a self-assessment tool which offers specific tailored advice or enables results to be sent to the SPA for follow up contact to be made. In addition, there are specific portals of information relating to dementia, sensory impairment and carers.

To support us in delivering person-centred care, we have developed a new Making it Real (MiR) area on our LiveWell site: https://livewell.nelincs.gov.uk/adult-social-care/making-it-real-how-to-do-personalised-care-and-support/ This sets out our commitment to the MiR framework which supports personalised care. We intend to build on this over the coming year.

New and revised information has also been drafted in a number of other areas, for example continuing healthcare (CHC), to ensure that it is comprehensive and up to date. New/ revised content is subject to review by a panel of community 'experts by experience' as part of a six-month programme of engagement activity, taking place from July 2022.

As noted in our previous plan, the Livewell site is integrated with another digital platform, Simply Connect - https://nelincs.simplyconnect.uk/ - which offers advice and information on community resources and activities such as 'knit and natter'. This resource has progressed significantly to include a wide range of community support mechanisms such as: therapists, support groups, care professionals, social groups/ events, childcare, health and fitness classes, outdoor exercise, legal advice, and financial advice.

Single point of access (SPA)

Our 'front door' remains a focus for continuous improvement. The SPA continues to offer integrated health, mental health, social care and therapy access for professionals and the public in NEL. For example, in quarter one (April – June 2022) the adult social care triage team fielded an average of 4,275 calls and the health triage function an average of 7,085 calls. Using the Govmetrics system,

SPA is able to secure contemporaneous feedback. For example, 100% of callers to the adult social care triage function that leave feedback, report a positive experience.

As of July 2022, a telephone call to the SPA now offers a further integrated option (option 5) which links to Connect NEL (the wellbeing hub referenced in our previous BCF plan, and part of our preventative offer). There are also electronic referral mechanisms via SystmOne, and opportunities for individuals to refer themselves by direct call or email to the wellbeing hub. Connect NEL offers a 24/7 helpful and friendly signposting service created to help people get 'in front of' the services and activities they need faster. It is free to access. It dovetails LiveWell, Simply Connect and Thrive NEL (see below). It provides a conduit to lower-level support provided via the voluntary and community sector and public health teams.

Priority: further develop our integrated information and advice offer (LiveWell), prevention offer (Connect NEL and Simply Connect), and engagement via the 'front door' (SPA), ensuring it is person-centred, and focused on promoting independence.

ii. Housing based help

Care home provision and support to care homes

The COVID -19 Pandemic continues to impact our residential providers, who remain under significant pressure from the risk of outbreaks and loss of staff due to illness. In this challenging time, we have completed our market position statement and we are now in the process of completing our fair cost of care exercise using the national tool kit.

Providers will soon be mandated to complete the Capacity Tracker on a monthly basis which may result in a less frequent level of data being pulled into the adult social care dashboard. To address this, we will soon begin developing our implementation plan for the PAMMS assurance system which should act as an adjunct to our existing assurance processes.

The falls project, run under the Support to Care Home programme, is being reviewed and it is hoped that in the future it may help to develop a pilot of the iStumble App which is supported by EMAS (East Midlands Ambulance Service). This would align with work being considered across the ICB.

Work is continuing to develop support from our five PCNs (primary care networks) to ensure that there is a consistent MDT offer available to all residential providers. The PCN care home clinical leads are also being asked to look at proposals for expanding pilot schemes that are being run in three care homes with the hope that this would be developed further and fully rolled out if possible.

Extra care housing

It remains our intention, as set out in previous BCF plans, to progress extra care housing (ECH) schemes as part of our accommodation with care offer. We currently have two schemes in the borough – Strand Court and Burchester Court – offering 120 units of modern, adapted, self-contained apartments. Our plans to develop such schemes have generally been behind schedule, but are making progress. We have undertaken a market testing exercise to understand what model best suits NEL and our needs, now and in the future. We are working on the following previously referenced sites:

- Cambridge Road (former Western School site). It is hoped this scheme will offer between 70-90 further units, with work to start in the next 18 months
- Davenport Drive (former Matthew Humberstone school site). This scheme should offer between 70-90 further units. The build for this site will be staggered following commencement of the Cambridge Road site.

Both Davenport Drive and Cambridge Road form part of wider housing development schemes by the Council. Agreement from Sports England has been granted (as these were both old school sites, with playing pitches) to use the land for ECH, and we are now appraising options to seek the best fitting model to support NEL population needs, including a self-delivery option via the Council. The Council, in consultation with Homes England, are developing a business case and are in the process of understanding the viability of this option. This could potentially see an income for the Council through the rents once the capital for the project has been repaid.

Priority: continue to ensure our housing-based help offer is a) sustainable, b) supported by appropriate professional input, c) sufficiently diverse to meet the needs of local people and enable independence.

iii. Care at home

Our 'teams not times' model continues to be the method for delivering support at home. However, we have also recognised that there is a need for a more enhanced skill set for care workers when delivering care to some residents with ongoing care needs. A pilot has been developed to provide some care workers with additional training to deliver PEG feeds, carry out simple wound care and support insulin dependent residents. It is hoped this will provide data on the amount of training and demand as well as the benefits to the cared for person, and help shape future commissioning specifications.

The just checking scheme referenced in our previous plans, continues to offer additional flexibility to our care at home model – helping to ensure that individuals receive the care they need when they most need it.

We have now secured a lead occupational therapist to deliver the single-handed care project, designed to improve the efficiency and effectiveness of support at home services within phase 1. We will do this by reducing the number of calls for two or more care workers through utilising improved techniques and different equipment suitable for moving and handling with one carer instead of two. The project aims to create a philosophy of reduced care handling; improving techniques for both the individual and the supporting person, and aiding people to be supported by their informal carers and/ or in their home for longer. The project will be delivered over several years across the following phases:

- **Phase 1: Quick wins**
  Working with support at home providers - who have already identified individual support packages which may benefit from reassessment with single-handed care in mind - to offer training, support and improvement of knowledge base to staff, informal carers/ formal care workers and the individual. This phase will include general awareness, support and improvement of knowledge base across a number of professionals, including social workers, therapists, and allied health professionals.
- **Phase 2: Wider community providers and complex cases**
  Assessing more complex cases in the community for single-handed care, and identifying cases in other services such as supported living, where the individual may benefit from single handed care techniques and approaches.
- **Phase 3: Care homes**
  Working with care homes to implement single handed care techniques and equipment. Developing a network of training and support to the staff in these homes to upskill and increase confidence.
- **Phase 4: Whole system**

Developing and embedding a whole system change to implement single handed care-based approaches, from hospital through to the community.

Support at home remains very challenging; providers face extra pressures from the requirement to support hospital discharge, as well as respond to increases in demand from the community. This is especially difficult given the high levels of COVID sickness and spread in the community.

Priority: appropriately resource and embed new support at home model to ensure personalisation and promotion of independence is maximised (evaluated using the Making it Real Framework).

iv. Reablement

Creating additional reablement capacity (step up/step down) remains a focus of activity during 2022/23, as well as improving length of stay and outcomes for individuals.

Work continued through 2021/2022 to launch Cambridge Park enhanced recovery unit as the main bed based intermediate care provision (referenced in our previous plans). The plus sized provision (2 ensuite bedrooms) has been completed and utilised continuously since its opening in spring 2022. The service is currently working to reach a capacity of 42 beds with an enhanced service offer to support those with more complex needs.

The reablement improvement programme will run over several years; updated priorities include;

- Increasing the capacity within our intermediate care bed-based facility (Cambridge Park, as above)
- Enhancing the offer in intermediate care to include enhanced nursing functions for e.g., intravenous therapy, PEG feeding
- Developing 10 block booked beds and a spot purchase provider framework to deliver additional enhanced recovery bed capacity to support discharge and avoidable admissions
- Undertaking the re-ablement review
- Working to improve the model, offer and performance of our intermediate care at home service
- Creating a re-ablement culture across NEL
- Delivering the singlehanded care initiative (see care at home section above).

The Council and CCG (now ICB)/ HCP have continued to work with the Assisted Living Centre (ALC) to improve the performance dashboard and financial monitoring of the service. The specification and revised KPIs (key performance indicators) are currently being approved. Demand and capacity work has also commenced to understand the volume and complexities of those presenting to the service. Joint work with the tissue viability nurses, the Council, HCP and the ALC has been progressing to ensure the right processes are in place to provide pressure relieving equipment for those at risk of having, or who have, pressure damage.

Priority: continue to ensure effective delivery of reablement provision and wider services which support it (e.g., the ALC), whilst working to embed a 'reablement culture' across all levels and types of support.

v. VCSE (voluntary, community and social enterprise)

Working collaboratively

In 2018/2019, the Council and CCG (as it was then) developed, with community members and representative of the VCSE sector as equal partners, a joint engagement strategy entitled 'Talking, Listening and Working Together'
(https://www.northeastlincolnshireccg.nhs.uk/data/uploads/engagement-strategy/twlt-final-digital-

a11y-accessible.pdf). This engagement strategy sets out NEL's commitment to routinely involving communities, talking to the public as early as possible and being informed by their experiences, concerns and aspirations. To help ensure communities are included in conversations, we aim to engage with VCSE organisations and seek their support to develop solutions for NEL. Engagement strategy implementation slowed during the pandemic, but plans are being made and implemented to reinvigorate its implementation over the current year. This is happening in several ways, including in respect of the Council/ ICB's relationship with the voluntary sector. Activity includes:

- Creation of an engagement toolkit to ensure that engagement with community and VCSE colleagues drives and informs HCP projects; this toolkit is being consulted on currently
- Reconvening the strategy steering group, which comprises community and VCSE representatives, to consider how best to develop the strategy, given the revised landscape (i.e., the CCG's replacement with ICB)
- Further development of key performance indicators to enable the steering group and others to assess the success of the strategy. Results are published in a 'you said, we did' format
- Creation of a programme of engagement activity, intended to offer a variety of opportunities for community members and VCSE colleagues to contribute to Place development
- Joint working on a number of projects including (for example) an initiative to reduce social isolation in different communities.

Supporting the sustainability of the VCSE sector

The ICB continues to fund Sector Support NEL Partnership (SSNEL) (https://www.sectorsupportnel.org.uk/) jointly with the Council. SSNEL supports not for profit organisations to build their capacity and infrastructure, through voice and influence, and support with funding, governance, and training. SSNEL represents the VCSE sector in the HCP and is the VCSE Lead at system and place. SSNEL is working with us to formalise the Council/ ICB/ HCP's relationship with the system based VCSE Collaborative and place based VCSE Assembly to draw the VCSE sector even closer to planning and delivery. Joint working with the voluntary sector has been crucial in meeting local need throughout the pandemic, and we want to build on that by taking further steps towards integrating the VCSE offer with more formal services. We will continue to explore strengths and assets, partnerships, knowledge sharing, Talking Listening and Working Together, and commissioning and procurement routes.

The BCF funded Preventative Services Market Development Board (PSMDB) continues to support preventative opportunities in the VCSE sector. In light of the pandemic, the PSMDB has successfully concentrated on ensuring that the projects developed have remained sustainable and delivered valuable services. This approach has led to a significant growth in the scale and range of services being delivered and a subsequent growth in the impact delivered.

This year the PSMDB has seen the development of a bike riding for the disabled programme, a new handyman service, a hairdressing service, a food bank, and a programme that will grit the paths of elderly and vulnerable community members to help reduce falls and their consequences.

Although Covid-19 has had a significant impact on the PSMDB's work, and progress has been hampered, work has continued as follows (figures given since PSMDB's inception, to 31st March 2022):

Total awards	£485,421
Average Award Size	£23,115
Additional Funds Levered	£1,745,219
For £10 spent by PSMDB, it has attracted an extra £5.95 into the local economy	
Total Combined funds invested in community services*	£2,192.640

Total spend in the local community	£1.9m
Value of that spend (LM3# £2.45 for every £1 spent)	£4,655.000

*PSMDB grant funding, organisations own contributions and external funding attracted
LM3 measures the multiplier effect of income into a local economy

Priority: continue to work with VCSE colleagues to ensure coordinated and accessible preventative opportunities, and use existing mechanisms to support projects designed to achieve the same.

vi. Workforce development, assessments and interface between services

As noted in previous plans, NEL has been promoting and embedding an asset-based approach to practice for some years. All staff micro-commissioning placements (social work, mental health, continuing health care and community nurse practitioners) work to our micro-commissioning policy which advocates an asset-based approach, and is reflective of the national ethical framework published during the pandemic. The asset-based approach is also embedded in the SPA, now strengthened through its links with Connect NEL and Simply Connect. VCSE and ICB teams will further work together with the aim of hosting events that support asset-based approaches, workforce and the interface between formal services and community services.

The programme of engagement on the recently updated micro-commissioning framework is continuing this year, to complement existing programmes of engagement and practice development noted in previous plans. Practice development events this year (offered to all commissioner and provider staff across health and care) include sessions on:

- Deprivation of liberty and the development of the Liberty Protection Safeguards (LPS)
- The Mental Capacity Act 2005 (MCA) philosophy and practice
- The MCA and tenancy
- Using the inherent jurisdiction to protect the vulnerable.

This programme of events also supports us in work to address inequalities (see equality and health inequalities section below). For example, a respected academic will visit NEL's Social Work Forum in September. The Forum is attended by social workers practicing across health, mental health, social care and voluntary sector partners, as well as by nurses. The academic will discuss his latest book and the extent to which systems exacerbate disadvantage. Professionals will be prompted to consider their role in mitigating disadvantage, and developing resilience.

A number of work programmes are in place to improve practice at the interface between services, such as that between adult services and housing. On this there is significant engagement and improved methods of working, pulling together the strategic, enforcement and home options teams in the Council as well as teams in the ICB and wider external partners, including private landlords and social housing providers. This positive interface between services/ partners continues to deliver a sustainable pathway to address homelessness/ housing issues. Work will continue to shape the pathway, supported by agreed principles for shared learning and working. This includes work via the Strategic Housing Action Plan to provide clarity and solutions for key housing challenges, as referenced in our previous plan.

Due to changes of personnel, work on the interface between children and adult services referenced in our previous plan, has not progressed in the way hoped for. This remains an area for further attention and development.

Priority: continue with the programme of work focused on ensuring staff identify individual outcomes and the progress towards meeting those outcomes, across the life course and across services.

vii. Collecting information

Following the work of Insights NEL (referenced in our previous plan), a newly formed team 'Strategy, Policy and Performance' commenced 1st August 2022. This is a new operating model that is aligned with ICB colleagues in the Contracts and Procurement Team. All work undertaken by this team is intended to benefit the wider Place.

The Data Group working group has completed work to understand which teams work with systems and data; this has led to the creation of a systems administrator group. The group is creating one information directory which will have a central location; this will be a 'yellow pages' of all data held. The group is also developing data quality standards and a data quality training package that will be launched over the next 12 months across the workforce. This group is part of the Insights NEL work that commenced last year. The group comprises Council and ICB representatives. The group has been responsible for mapping business processes across the Council and CCG (now ICB) to understand current processes and where data is held.

A new Customer Service Management Platform is being procured (currently at tender evaluation stage). This new platform offers the capability to integrate business activity with customer engagement in a meaningful way. By creating a central customer database, it will be possible to effectively develop links between service applications, enabling better understanding of customer needs and helping to inform strategy development and service improvement. It will improve the utilisation of applications, reduce application management resource, and improve integration across services. This will also enable evidence-based decisions by using the intelligence held within data sets. Within this platform 'project management software' all information will be captured in one system for all projects that are worked on. This new application will deliver a key commitment to "join up our data and insights capability to make sure we make the best use of all the information and intelligence held across the Place, and that services are delivered in a way that is more efficient and responsive to the needs of our population". The system will be utilised by the Council and HCP.

Priority: further develop the comprehensive Union approach to insights which allows effective targeting of resources and greater benefits for the residents of NEL.

b) Approaches to joint/ collaborative commissioning

All BCF initiatives are commissioned via the s75 agreement. Governance for joint/ collaborative commissioning is likely to be provided via the Health and Care Joint Committee (referenced in the Governance section at the beginning of the plan).

The health and social care needs of the service user/patient are not separated. For example, in NEL our CHC team and social care team work collaboratively under one decision making policy – resulting in zero disputes over our funding packages in over a decade. The patient's experience is streamlined to ensure that needs are identified and rapidly supported from all viewpoints. The aim is that:

- Health and social care needs are recognised across teams
- Services share information and alert each other of patient changes
- Services identify any gaps in provision and work together to overcome identified problems
- People only need one assessment with no passing around of responsibility.

c) How BCF services support integration/ any changes

The 'joint priorities' section above sets out how BCF services support integration and any relevant changes to date, or planned for the remainder of the year. The remainder of this section focuses on

the enablers of that integration, updating information given in our previous plan on organisational approach, digital developments and workforce.

Organisational approach

So far as legally possible, the CCG and Council achieved integration via a Union, reflected in updates to the s75 agreement which has been in place since 2007. The s75 has been updated again to accommodate the advent of the ICB. Staff continue to be co-located so that health, care and public health commissioning teams work in the same building and are led by a joint management team and chief executive. This arrangement continues to form the bedrock of integrated activity in NEL.

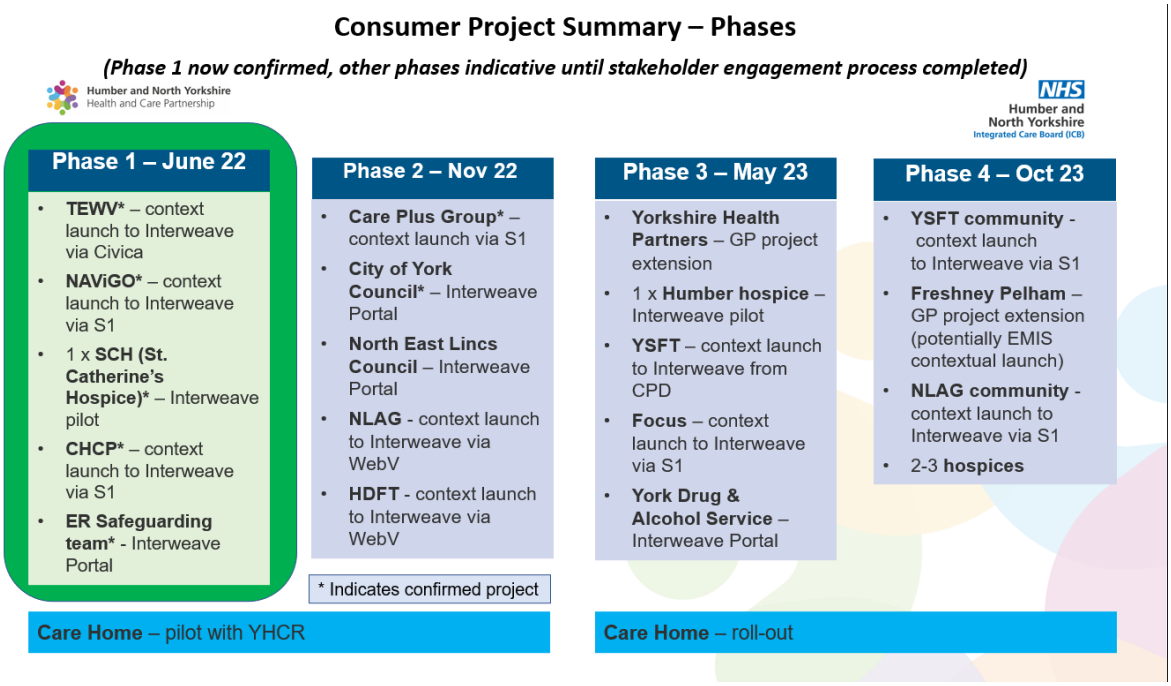
Prior to the introduction of the ICB, a single Union commissioning plan was developed, underpinned by a set of shared core commissioning principles designed to reflect the findings of the Adult Services Review, aligned with our Adult Strategy. The same principles of shared commissioning against agreed outcomes for NEL still stand and will further develop under the new ICB arrangements. The Union was supported to develop further by FutureGov, via an integration road map which sets the standard for decision making, culture, and organisational design. Local teams will continue to take this work forward, to ensure the Union's vision is realised: "to grow and enhance the place of NEL to improve the health, care and life experiences of our population".

Digital enablers of integration

Building on our success and expansion of the initial SystmOne and EMIS integration, we have continued to develop our record sharing technology and ethos with the maturing of our Yorkshire and Humber Care Record (YHCR) and Electronic Palliative Care Coordination Systems (EPaCCS) solution. Several Organisations are now live with data connections into the YHCR including:

- 4 live NHS hospital trusts
- GP practices
- 4 live local authorities
- 2 x 999 providers
- YAS 111 Service
- End of life records.

As we move past the MVS 1.0 Standard into MVS 2.0 we have planned the following 4 phase deployment over the next year.



The YHCR system will also support improved Population Health Management toolsets.

Where appropriate we are working towards true electronic patient record convergence to further bolsters professional empowerment.

End of life record sharing has also matured, with a single HCP wide EPaCCS solution now in place. End of life preferences are entered and shared in real time between all partners included in a patient's care; this includes:

- Primary care
- Community care
- GP out of hours (OOH)
- Single Point of Access
- Secondary care
- Hospices
- 111
- 999 ambulance services.

This system ensures that professionals have access to the very latest patient preferences and are fully empowered to make decisions.

We have adopted the NHS APP as our standard front door to patient held records and have integrated the primary care PHR facilities with secondary care records via direct integration with the PKB product. VCSE colleagues have also undertake work to promote the use of the NHS App.

We continue to work with primary care on ensuring best use of public facing digital offerings by providing online and video consultation facilities, along with working directly with Primary Care Networks (PCNs) to ensure that digital maturity of staff and patients is understood. We have also deployed smart patient messaging systems to improve patient knowledge sharing and improve 'did not attend' rates.

We have been the NHSE national pilot site for the production of supportive materials to empower practices to educate practices on the most appropriate access point for them.

We continue the work to support the unplanned and emergency care position by ensuring that appropriate logistics and booking enabling tools are in place. We have provided the ability to:

- Allow 111 to book into emergency departments with a timed slot
- Allow 111 to book into urgent treatment centres
- Allow 111 to book into primary care
- Allow the NEL SPA to book into emergency departments with a timed slot
- Allow the NEL SPA to book into primary care.

We are also starting to provide the ability to book & stream unheralded emergency department walk-ins into the most appropriate location.

To further enhance patient care in the urgent and emergency care setting we are developing a booking and referral system to allow patients to be booked directly from one service into another service, reducing delay and administrative overheads and greatly improving the patient experience. We will also look to extend this facility beyond urgent and emergency care settings.

To ensure quick and secure channels of communication between clinicians we are implementing a dedicated clinical messaging solution across the ICB, which will allow clinicians to communicate with each other to agree the most appropriate care and location for the patient - right care, first time.

We have worked with care home partners to increase the digital maturity of care homes, and ensured that every care home has access to:

- Secure Wifi (which can be augmented with local funds to cover the whole site)
- NHS Mail
- A NHS Laptop
- A 4G enabled tablet for direct remote clinical consultations.

Across the HCP we have formed an (award winning) Care Home Digital Maturity service to assess the digital maturity of care homes and support them to improve the connectivity into the wider care community. This service has been very well received and is making a positive difference.

Workforce enablers of integration

NEL continues to battle long standing challenges in recruiting and retaining health and care professionals; these challenges have been exacerbated during the pandemic. Whilst BCF monies are not directly funding recruitment activity, workforce capacity concerns are of relevance to BCF in so far as BCF schemes require staff to deliver them.

Workforce capacity remains one of the biggest risks to the local health and care system. For that reason, we continue to work with partners to explore mechanisms to improve recruitment and retention of staff at all levels. For example, we held a workshop to ask our providers for feedback on what they consider to be the main issues in recruiting and retaining staff. We hosted a survey for all care staff to ask them similar questions, and had a very good response rate. We aim to use the survey data and workshop feedback to plan our next steps.

We continue to use events and other methods to promote roles in heath and care. For example, we produced inspiring videos with local care staff, which we promote via social media as part of a marketing campaign. We are also working with our providers to support the 'I Care' event in September 2022. This career event will promote the range of roles on offer and encourage people to consider a role in health and social care.

We are working with the Humber wide teaching partnership to consider social worker recruitment and retention across children and adult services. We also have in place close working arrangements between children and adult services in respect of ASYE (assessed and supported year in employment), in line with Skills for Care. This includes children and adult social workers across NEL being subject to the same internal moderation processes during their ASYE.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Enabling people to stay well, safe, and independent at home for longer
Our Adult Strategy – referenced in our previous plan and throughout this one - is our approach to enabling people to stay well, safe and independent at home for longer. The Strategy's vision is: "Adults in North East Lincolnshire have healthy and independent lives with easy access to joined up advice and support which help them to help themselves". We describe this vision as a 'promoting independence model': our support offer is designed to work alongside the person, to find ways of helping them that maximises opportunities for greater health and independence, and minimises the need for help. Support for adults is intended to be reablement based, challenging people to do more for themselves, and consistently reassessing their ability to maintain, gain or regain skills wherever possible. Success is defined by how far people have been re-abled (helped to maintain, gain or regain their health and independence, as much as this is possible for them).

The Adult Strategy is a Place strategy. All health and care commissioning, whether BCF funded or otherwise, is approached in the same way i.e. for the benefit of Place and intended to enable people to stay well, safe and independent at home for longer. To take one further concrete example (referenced in our previous plan) of joint commissioning, the CCG (as it was then) and Council staff jointly reviewed our day opportunities offer. Engagement with over 200 users of day services, service provider organisations and others enabled us to gather information about current services, and assess the degree to which such delivers on the Adult Strategy's vision. The review's findings are published https://livewell.nelincs.gov.uk/day-opportunities-survey/, and are being utilised to inform next steps. A 'you said, we did' document sets out those next steps (available via the same link). In short, day opportunities are being redeveloped to ensure that they are accessible to those who want to use them (regardless of funding responsibility), offering flexible and varied activity to meet a range of needs. A revised offer will aim to promote independence for both users and carers.

We acknowledge that there is more work to do, if we are to make greater progress on promoting independence. The diagram below (headed 'local approach to adult support') sets out that our reablement model is intended to be iterative in that it continues to reinforce the importance of independence – and taking an asset-based approach – at every stage of an individual's 'journey'.

As already largely noted above and in previous plans, this approach is supported in a number of ways including:

- our developing commitment to Making it Real (a step towards promoting personalisation)
- our micro-commissioning policy which underpins an asset-based approach to individual commissioning across CHC, mental health and adult social care
- our collaborative approach to individual commissioning which via a panel comprising representatives from CHC, mental health and adult social care, packages of care are subject to check and challenge i.e., are packages as 'independence promoting' as possible?
- our programme of legal literacy for staff, intended to foster a rights-based approach to delivery across health and care. A rights-based approach means understanding relevant legal frameworks and applying them to individuals in way that fosters personalisation and an asset-based approach.

Right care, right place, right time

The offer of extended access to general practice Monday to Friday 8am to 8pm and weekend opening continues and is being slightly amended from October 2022 as it is incorporated as one of the national specifications for PCNs (primary care networks). It continues to be delivered on a collaborative basis by local practices working together within their PCN groupings. The total hours per week that PCNs have to offer will increase slightly from October 2022, as this specification has been combined with a previous practice level extended hours specification. The opening hours for a Saturday are now mandated as 9 am to 5 pm (previously this was locally determined) and there are no requirements for a Sunday unless demand dictates otherwise; previous Sunday demand was extremely low, so local plans do not factor in Sunday opening hours. The local offer will include a mix of face to face and digital support, will be a multi-disciplinary approach, including GPs, nurses, HCAs (heath care assistants), clinical pharmacists, physiotherapist, ANP (advanced curse practitioner) and paramedics, and will include a mix of planned and urgent appointments covering services such as:

- Planned medication reviews / mental health follow ups

- Routine HCA/ nurse appointments for blood tests, health checks/ chronic reviews
- Counselling support services
- Structured medical reviews from clinical pharmacists
- Social worker support services.

The joint work with local VCSE organisations to deliver a successful social prescribing programme – Thrive NEL - continues. This was further expanded during 2021/22 through a combination of expansion of the Thrive service including incorporating a broader range of conditions, and additional recruitment to the Social Prescribing Link Workers that are part of the national PCN Additional Roles Reimbursement Scheme. This means that the PCNs can provide a named link person/ lead for the PCN population. Currently around 60 patients per month are benefiting from community support to help them manage their long-term conditions more effectively. A more detailed evaluation of the impact, in terms of the difference the interventions have made to those patients, as well as the reduction in the use of health and care services, is planned for Thrive towards the end of this year.

Primary care continues to deliver its enhanced specification to support residential settings, and this has further been developed to ensure that these standards are met. All PCNs have aligned residential homes and they have established multi-disciplinary teams, although these do operate differently dependent on the PCN and the requirements or preferences of the care homes. Overall, this has led to the development of good relationships with most care homes and effective engagement with the MDT, but there are still areas where further development is ongoing.

Providing the right care in the right place at the right time
The diagram below sets out the HCP's operational model, designed to deliver the right care in the right place at the right time. In particular the model is intended to direct people away from acute care and towards community and home care options wherever appropriate, as depicted in the funnel of transformation on the left of the diagram (and referenced in our previous plans).

Intentions re improving our data collection are referenced above. PCNs will be able to use a wealth of detailed data. Along with their local knowledge, this will give them greater insight into where the significant issues are within their local population. Multi-disciplinary teams, which will include a broad range of professionals linking closely with other health, social care and voluntary services, will be able to identify how to best address health issues within specific communities and support self-care and independent living. The benefit of working with partners outside of health will mean these approaches will not look like traditional health or care delivery. This will support people who might otherwise find it difficult to access care or whose wellbeing difficulties are related to their situation rather than to being poorly.

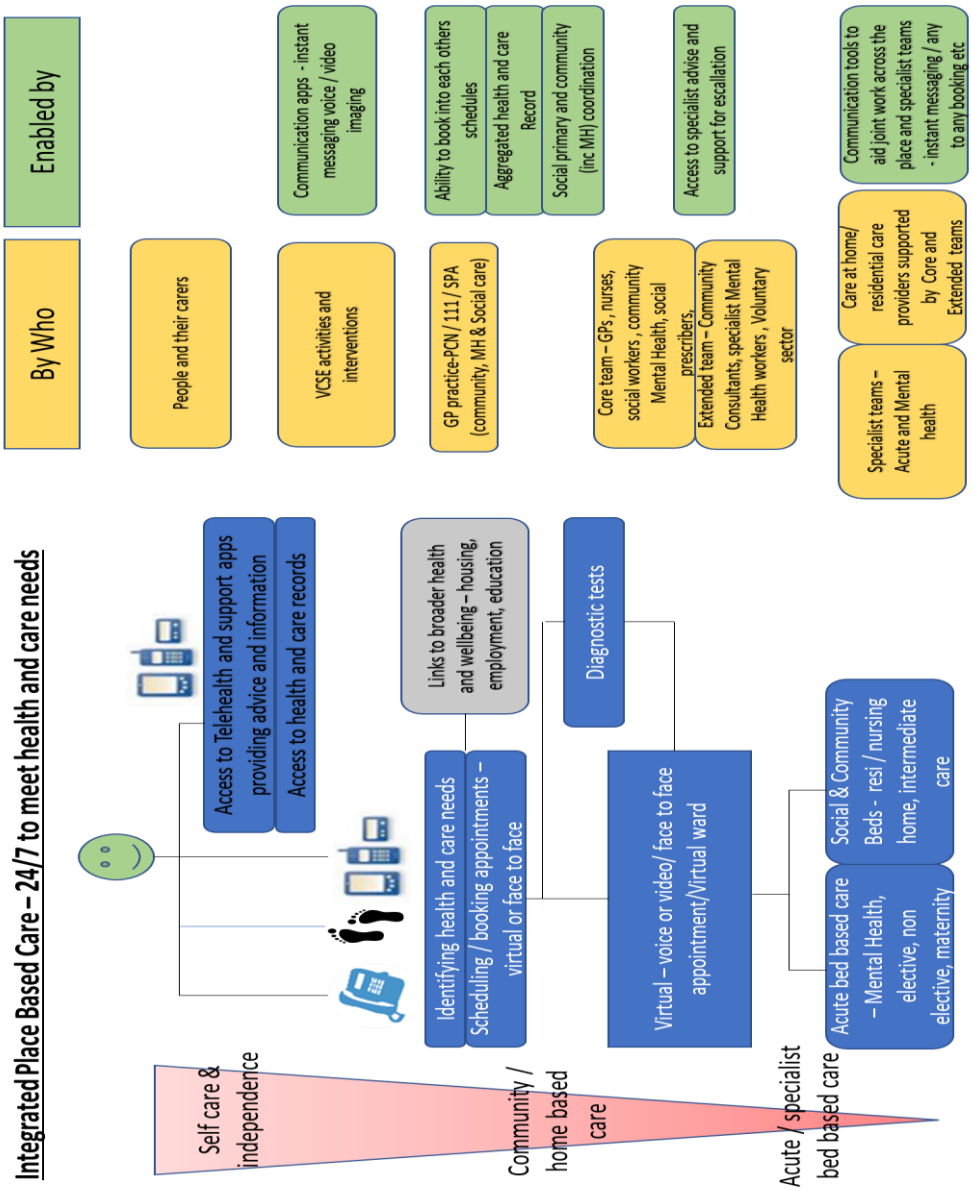
We plan to create intensive collaboration between different practitioners in the form of Accountable Care Teams. This means we will have teams of practitioners covering different areas of care who will focus on how best to meet the needs of individuals. The functions of the teams will align to the overall priorities of the HCP:

- Each Accountable Team will be responsible, empowered, and supported to deliver changes needed within their area
- Each team will work across organisational boundaries
- Each team will adopt a flexible approach, developing what works and changing what is less effective
- Each team will report to the HCP Professionals Forum for feedback, support, to unblock difficulties, and 'join the dots' so that practice is overseen and evolves over time.

In addition to planning to deliver the right care in the right place at the right time, mechanisms are in place to ensure that problems with delivery are proactively addressed. For example, in addition to ICB contract monitoring and Care Quality Commission regulatory monitoring, provision of commissioned health and care is overseen by the Market Intelligence and Failing Services Group ('the MIFS Group'). The MIFS Group comprises representatives from across health and care, pooling expertise from a range of disciplines. It protects the interests of those with needs in circumstances where providers are finding it difficult to deliver safe and quality services. The Group ensures the regular flow of information about such providers, pooling and analysing intelligence collectively. The Group takes collective action in response to failing or interrupted services; for instance, temporary suspension of referrals until difficulties are remedied, or coordinated action to assess and relocate all residents from their closing care home, regardless of whether they are CHC or social care funded.

The MIFS Group is closely linked with the work of the ICB's quality team. The team facilitates multi-disciplinary professionals to collectively review health and care system intelligence (reported via the shared portal and recorded via incidents and serious incidents). The aim is to seek assurance that problems are properly rectified, share positive practice across the system, and ensure learning is utilised to support wider quality improvements for the system. The team ensures the trends and themes are analysed and followed up, either directly with the provider of care, or for the benefit of all by including items of learning in a widely disseminated bulletin. In conjunction with themes from our shared health and care PALS and complaints function, targeted action helps ensure that the right care continues to be delivered in the right place at the right time.

HCP operational model



Discharge

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue 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.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

A significant amount of work by all HCP partners (including the hospital trust) has gone into improving the local discharge arrangements and ensuring that we are compliant with national guidance (April 2022).

We have made minor adjustments to our system to ensure we are aligned to the new discharge guidance (April 2022). The model mirrors the mandated requirements in previous iterations of discharge guidance as we have maintained nurse/ health led discharges with input from social care as required. Twenty-four hours after discharge each individual is followed up by an appropriate professional to undertake a full review of the person's needs and follow them through their recovery, recouperation and re-ablement journey. A full needs assessment is then undertaken if longer term needs are identified. BCF funding has funded additional capacity within the hospital discharge team (nurse led) and the community discharge team (social work) to ensure discharge to assess processes can be followed.

Daily community hub meetings are now common practice. These MDT meetings have been expanded to include representatives from the main onward care routes to ensure there is oversight of each person discharging on pathways 1-3 (circa 35 people/ week), following them through their onward care journey to ensure their needs are met. While the daily hub meetings have been very effective in facilitating discharges, the MDT approach begins when a patient no longer has a criteria to reside. To move to a more proactive approach, we have appointed two new proactive discharge coordinator roles which will ensure that discharge planning commences from the point of admission for those who are or are likely to be on a 1-3 discharge pathway from hospital. The roles and daily community hub meetings enable the delivery of change 1,3,4 and 7 of the HICM.

In NEL we are working wherever possible to the principle of 'home first', supporting individuals with voluntary sector support via the British Red Cross and Friendship at Home for example, which has been funded from existing budgets/ winter surge monies. Plus, the provision of commissioned services via pathway one where necessary. The support at home offer (domiciliary care) has continued to be bolstered through 2021/2022 and into 2022/23 due to increased volume and complexity of individuals. On average 95% of people discharging are going home first. This has helped us delivery against the HICM change four.

In addition, BCF funding has been used to contribute to the continued delivery of Cambridge Park our enhanced recovery unit. As noted above, this service is currently going through a phased implementation. The service - once it has reached capacity - will be 42 beds (with an aspiration of 50 beds in the future). Our intermediate care/ discharge to assess bed-based offer within care homes was increased to support with current demand. Following a review of this a slightly different model is currently out to expression of interest to procure 10 block book enhanced recovery beds and a spot purchase framework, delivering to the enhanced recovery specification. These placements will be available from mid-September onwards (this work links to delivering HICM change 2).

The bi-weekly discharge system improvement group continues to grow and is becoming a driver for change, supported by a weekly operational group to deliver the improvements required. A recent self-

assessment against all of the associated discharge guidance, HICM, 100 day discharge challenge and general best practice has led to a discharge system improvement plan, which has recently been signed off at the discharge system improvement group to address any areas for further development. The discharge executive lead oversees the discharge system across Northern Lincolnshire working with neighbouring authorities as required to ensure blockages/ issues are identified and addressed in a timely manner.

In 2022/23 the areas for development are the full operation of Cambridge Park, launch of the enhanced recovery bed block and spot purchase framework, fully embed the newly appointed discharge planning coordinator roles, launch of a discharge SOP (standard operating procedure) for all HCP partners to sign up to clearly articulating roles and responsibilities, develop an NEL discharge and onward care performance dashboard and work to further develop the home first pathway with the launch of the enhanced support at home offer. The delivery of these areas for further development will help us further our maturity against the HICM in change 1,2,4 and 7.

The BCF has funded many elements of the discharge and onward care process including developments in intermediate care to support a timely discharge from hospital for those without a criteria to reside who require a period of rehabilitation and reablement. The service is already seeing improved outcomes for individuals, with 20% of individuals returning home with no on-going support required.

The BCF also funds additional staff to support with the delivery of 7 day working to facilitate discharges 8am-8pm 7 days a week, meaning that individuals are supported to discharge on the same day wherever possible. The additional staff include increased nursing staff to bolster capacity within the hospital discharge team, additional social workers to support holistic needs assessments within the home environment, additional care staff to support within intermediate care services and support at home provision.

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.

NEL offers a number of supportive services which are free to unpaid carers, including (but not limited to) carers' breaks via holistic therapies, activity groups, wellbeing groups, visits and trips for peer support and social inclusion, access to training and learning, and a summer support scheme. There are also free advocacy services, befriending, 1-1 focused support, specialist mental health and dementia support, home support (domestic help and carers' sits), and personal care services for the cared for person (in order that a carer with a more complex care role can access breaks and/or necessary life appointments (e.g., for their own health)).

The current year's action plan builds on the work of previous years and ties in with regional aspirations to improve identification of carers, by increasing the range of options for self-referral, improving the ease of access to referral options for professionals, training professionals to better recognise carers and removing barriers of language for communities so they can recognise their caring role (i.e., via targeted social campaigns, and digital solutions). The plan also covers better integration of carers in service feedback systems (ensuring carers are on panels and boards; for example, a carer has recently joined the hospital board), better recognition of carers in learning settings (e.g., schools), and improved partnership working between the council and HCP to ensure a fairer offer for carers of all ages. There are actions to target working carers, via their organisations, to ensure that working carers are empowered and supported to remain in work while caring (through improved awareness/ cultures, carer policies and carers' passports); a carers' charter is also in progress, which will identify carer friendly organisations, ensuring that carers returning to work will be able to choose environments that are supportive to their carer needs. Ongoing work with the hospital, halted due to covid, has also restarted regarding the flexible visiting scheme for carers of those in hospital, to enable carers to support their loved ones while they are admitted.

BCF supports a significant proportion of our prevention, wellbeing and universal support offer for carers.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

DFG progress has been severely challenged in the last few years, resulting in increased waiting times, labour shortages, increase in costs, and a reduced supply chain effecting the delivery of materials. All continue to affect performance.

However, despite these challenges, there continues to be a greater focus on the DFG agenda. Operationally, occupational therapy (OT), technical team and commissioners meet on a monthly basis to ensure the delivery of the DFG agenda and support creative ways to reduce waiting times and improve outcomes for people through utilising the DFG budget innovatively. This includes continued application of the local Housing Assistance and Disabled Adaptations Policy (launched late 2019 and referenced in our previous plan). Arrangements have been bolstered with a complete review of the DFG process including a new performance template (from inception to completion of works) enabling all key activities that make up the DFG process to be individually scrutinized, performance assessed, managed and monitored by the Operational Team and Strategic Oversight Group.

The DFG strategic group continue to meet monthly with partners from social care, housing, health and finance from across the local authority and ICB to monitor spend. The group has oversight of the delivery of mandatory and discretionary DFGs, and plans the delivery of wider innovative projects under the Council's discretionary powers to support the people of NEL with their housing needs. Several schemes have started over the last year, including:

- increasing the surveying and OT capacity on site, which includes the recruitment of 5 new employees, focused purely on reducing waiting times.
- The development of an award-winning scheme, Cordage View, which was supported by DFG funding to meet a range of complex needs, future proofed adaptations and infrastructure, and assistive technology to foster independence.
- The formation of a minor adaptation 'handyperson' service to capture those low-level adaptive needs that present within SPA; this could see the installation of lower-level equipment around the home such as grab rails and more; helping to keep people at home and independent for longer.

We are working to develop the scope of the handyperson service to respond to holistic housing needs assessments including thermal warmth, sustainable energy, securing loose carpets, and other repairs and maintenance around the home that may impede an individual in having easy egress around their home or which pose a risk of falls.

As indicated in our last plan, we continue to foster an innovative approach (delivered by the DFG Operational Group, which reports to the Strategic Oversight Group) to ensuring the DFG is used to support people to live as independently as possible in their own homes, including:

- Working to support those who have waited for suitable adapted housing on our home choice links register by acquiring stock from social landlords
- Improving the thermal comfort of those who have health conditions which are exacerbated by damp and cold environments

- Utilising existing housing providers across the borough to support DFG adaptations to reduce the DFG waiting times for those in supported living, allowing works to be completed more quickly to support complex needs.
- Developing a trusted assessor approach to minor adaptations, delivering a more direct service and reduced waiting times.

DFG work is undertaken by the Council, ICB and wider partners.

Housing and the DFG lead have been engaged in the development of this BCF plan.

Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

NEL's approach to tackling health inequalities remains broadly as set out in our BCF plan 2017/19 (pages 14/15) and reiterated in subsequent submissions. As summarised in our last plan, schemes are intended to address inequalities by being accessible to/ reaching out to local people in their communities in a way more likely to tackle disadvantage and increase resilience.

The NHS 2021/22 Priorities and Operational Planning Guidance: Implementation Guidance ('the Guidance') states that the pandemic has highlighted an urgent need to address inequalities. Similarly, the pandemic has amplified existing health inequalities in NEL and continues to impact on provision and planning. The conclusions of the 2020 Director of Public Health's annual report, focused on tackling health inequalities and referenced in our previous plan, remain pertinent. For example, it remains true, as the report highlights, that individuals living in deprived communities are less likely to consume preventative NHS care, to identify risk factors, and to present to healthcare services at an early stage of illness. Such communities are therefore more likely to be admitted to hospital as emergencies and at a later stage of illness, and to suffer worse outcomes. Connect NEL is supporting reduction in inequalities by providing an alternative, non-statutory route to access support and services. Where necessary it builds individuals' confidence through access to other help which supports them to engage with the services they require. By supporting people in this way, we hope to provide inclusive services and proactively engage those at greatest risk of poor outcomes (Guidance priorities one and four).

Changes in the delivery of healthcare during the pandemic, with a focus on more remote methods of delivery for appointments, may have exacerbated inequalities in access, with some groups potentially facing digital exclusion due to factors such as age, skill, income, or lacking devices, data, Wi-Fi and/ or a safe, calm space to engage in digital appointments. Work on digital inclusion and inequality within the system, and at place, is in development. Projects have and are being piloted within the VCSE sector to respond to digital barriers with a view to growing, duplicating and evolving successful projects in the future. Efforts to mitigate digital exclusion support us in addressing Guidance priority two.

ICB and public health colleagues continue to work across the HCP in a range of ways to tackle inequalities in the broadest sense and in ways which are reflective of the CORE20PLUS5 approach; some non-exhaustive examples include:

- Responding to the digital barriers that those with serious mental illness can face (e.g. limited access to technology), there has been a re-focus on annual physical health checks for this population. These can be delivered in person, in people's homes
- Recognising that people with learning disabilities have been adversely affected by both Covid-19 and the social restrictions imposed in the management of it, there has been a

campaign to increase the number of annual health checks completed for this group, and a bowel cancer screening programme, reasonably adjusted to the needs of those with learning disabilities, has commenced. This has involved working with the Learning Disability Wellbeing Team, who can support patients with learning disabilities to explain the health check/ screening, and work with practice staff to ensure that they understand any reasonable adjustments required by those with learning disabilities

- As access to mental health support has been challenging for many, including those who are or were looked after children, the ICB is seeking to introduce a more trauma informed approach via training. Workers have been introduced in several primary care networks (PCNs) which can connect people into VCSE support or into primary or secondary care services as appropriate, stopping people being passed 'from pillar to post', and helping respond to any social issues which may contribute to or exacerbate mental ill-health
- Partnership working between local authority, ICB, and adult mental health provider (Navigo) has seen development of dedicated mental health nurse to jointly support rough sleepers, who often suffer significant disadvantage
- In response to falls in diagnosis rates for dementia, due to reduced referrals into and out of primary care during the pandemic, information and support campaigns have successfully been established meaning referrals to the Memory Clinic are now nearing pre-pandemic levels.
- Creating population data packs for each of our PCNs that identify each PCN's 20% most deprived to facilitate starting conversations about areas/patient cohorts PCNs want to focus their CORE20Plus5 approach on. The intention is to surface "hot spots" of health inequalities and provide a very localised approach to tackling them.

Following the establishment of ICB and HCP, the Union Equality & Diversity Core Group mentioned in our previous BCF plan will become a HCP Equality, Diversity & Inclusion (EDI) Group. The EDI Group will build on the work of the Union E&D Group and continue with Equality Impact Assessment paperwork. The Group's membership will be broadened to include all local partners, and will work to ensure the HCP:

- takes into account the National Healthcare Inequalities Improvement Programme and the CORE20PLUS5 approach
- meets the Public Sector Equality Duty as outlined in the Equality Act 2010 in our direct service delivery and commissioned activities
- works to ensure equitable and inclusive health and care services in NEL,
- works together and with other partners to reduce health inequalities across NEL
- promotes equality, diversity and inclusion across our workforce and communities.

The EDI Group aims to contribute to strengthening leadership and accountability for tackling health inequalities at Place, in support of the Guidance priority five. Local leaders have expressed the intention to develop a Place based EDI strategy and to ensure that work on this topic is directed by and fed into the Health and Wellbeing Board.

The revised Group's key tasks will include:

- monitoring the quality of Equality Analysis and Impact Assessment for service development, strategies and policies
- ensuring procurement processes and ongoing contract monitoring promotes equality and diversity
- participating in the monitoring of equality, diversity and inclusion in the delivery of NEL's engagement strategy (the NEL Commitment to 'Talking, Listening and Working Together')

- overseeing the development and delivery of a joint resource for EDI training, ensuring it incorporates equality impact assessments for staff and volunteers.

As inequalities exist in NEL for those grouped by factors other than protected characteristics, the following groups have also been considered in the work of the Union E&D Core Group (and will continue to be considered by its successor, the EDI Group):

- those with Veteran status
- those living in areas of deprivation
- unpaid carers
- care leavers
- Looked after children.

We referenced earlier in our plan (see page 10) the importance of drawing on accurate data to help us assess whether our efforts to deliver effective services and tackle inequalities are successful. The planned information directory acting as a 'yellow pages' of all data held, in conjunction with the new platform to enable evidence-based decisions using data intelligence, will support the work of the EDI Group. Such is also reflective of the requirements of the Guidance priority three.

To ensure that health and care services are designed and delivered in a way which promotes equity of access, we must ensure that engagement and communication methods take into account the needs of people with a protected characteristic, so that those with a protected characteristic are able to fully participate. Communication and engagement activity is monitored. The latest published report can be viewed here: https://www.northeastlincolnshireccg.nhs.uk/data/uploads/equality/nelccg-engagement-equality-monitoring-report-20-21.pdf

More information can be found here: Equality and diversity - NELC | NELC (nelincs.gov.uk) via which a report made in April and updated in June 2022 is available, setting out further detail on local plans (https://www.nelincs.gov.uk/assets/uploads/2022/07/Equality-Report-June22-a11y.docx) .

BCF Planning Template 2022-23

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

Note on viewing the sheets optimally

For a more optimal 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 sheet for readability if required.

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

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund 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 (click to go to sheet)

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).

4. Income (click to go to sheet)

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 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. 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.

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

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.

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

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, 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 Conditions 2 and 3 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 5b.
- 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. 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 National Condition 2.
- 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.
6. 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 under National Condition 3. 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.

7. 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.
8. 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.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

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 2022-23. 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 2022-23.

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 a planned rate for these admissions, per hundred thousand people by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but we are only relying on the rate per 100,000 population instead of the indicator value and also in the interest of timeliness, relying on the latest available population data.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the quarter.
- The denominator is the latest local population based on Census mid year population estimates for the HWB which as of May 2022 is 2020/21 (we are aware that this doesn't match the numerator timeframe)
- Actual performance for each quarter of 2021-22 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.
- Exact script used to pull pre-populated data can be found on the BCX.
- 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-
2. 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 2021-22, 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 2022-23 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 2021-22 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.

3. Residential Admissions (RES) planning:
- 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 2021-22. 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.

4. Reablement planning:
- 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 2021-22. 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.

7. Planning Requirements (click to go to sheet)

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 Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 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 2022-23 Template

2. Cover

Version 1.0.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

Health and Wellbeing Board:	North East Lincolnshire
Completed by:	Emma Overton
E-mail:	emmaoverton@nhs.net
Contact number:	0300 3000 662
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	Fri 23/09/2022
If using a delegated authority, please state who is signing off the BCF plan:	Cllr Stan Shreeve

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of Health and Wellbeing Board
Name:	Cllr Stan Shreeve

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Stanley	Shreeve	stanley.shreeve@nelincs.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Ms	Jane	Hazelgrave	j.hazelgrave@nhs.net
	Additional ICB(s) contacts if relevant	Ms	Laura	Whitton	laura.whitton@nhs.net
	Local Authority Chief Executive	Mr	Rob	Walsh	rob.walsh@nelincs.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Simon	Galczynski	simon.galczynski@nelincs.gov.uk
	Better Care Fund Lead Official	Ms	Emma	Overton	emmaoverton@nhs.net
	LA Section 151 Officer	Ms	Sharon	Wroot	sharon.wroot@nelincs.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 -->	Place Director	Ms	Helen	Kenyon	helen.kenyon@nhs.net

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. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: North East Lincolnshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£3,220,832	£3,220,832	£0
Minimum NHS Contribution	£13,994,082	£13,994,082	£0
iBCF	£8,058,576	£8,058,576	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£25,273,490**	**£25,273,490**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£3,976,721
Planned spend	£8,934,043

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£2,052,691
Planned spend	£5,060,039

Scheme Types

Assistive Technologies and Equipment	£1,094,774	(4.3%)
Care Act Implementation Related Duties	£867,783	(3.4%)
Carers Services	£317,250	(1.3%)
Community Based Schemes	£4,766,265	(18.9%)
DFG Related Schemes	£3,220,832	(12.7%)
Enablers for Integration	£457,675	(1.8%)
High Impact Change Model for Managing Transfer of (	£0	(0.0%)
Home Care or Domiciliary Care	£86,000	(0.3%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£5,695,671	(22.5%)
Bed based intermediate Care Services	£2,665,981	(10.5%)
Reablement in a persons own home	£4,220,288	(16.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£107,836	(0.4%)
Residential Placements	£1,030,293	(4.1%)
Other	£742,842	(2.9%)
Total	**£25,273,490**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)			

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.5%	92.5%	92.5%

Residential Admissions

		2020-21 Actual	2022-23 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	634	723

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.0%

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 2022-23 Template

4. Income

Selected Health and Wellbeing Board: North East Lincolnshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
North East Lincolnshire	£3,220,832
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£3,220,832**

iBCF Contribution	Contribution
North East Lincolnshire	£8,058,576
Total iBCF Contribution	**£8,058,576**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

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

NHS Minimum Contribution	Contribution
NHS Humber and North Yorkshire ICB	£13,994,082
Total NHS Minimum Contribution	**£13,994,082**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding

Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£13,994,082**	

	2021-22
Total BCF Pooled Budget	**£25,273,490**

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

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: North East Lincolnshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£3,220,832	£3,220,832	£0
Minimum NHS Contribution	£13,994,082	£13,994,082	£0
iBCF	£8,058,576	£8,058,576	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£25,273,490**	**£25,273,490**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£3,976,721	£8,934,043	£0
Adult Social Care services spend from the minimum ICB allocations	£2,052,691	£5,060,039	£0

>> Link to further guidance

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	prevention	prevention	Prevention / Early Intervention	Other	Falls prevention	Community Health		CCG			Private Sector	Minimum NHS Contribution	£107,836	Existing
2	Dementia	Dementia	Community Based Schemes	Other	Community Dementia support	Social Care		LA			Private Sector	Minimum NHS Contribution	£200,000	Existing
3	7 day working	7 day working	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Private Sector	Minimum NHS Contribution	£216,708	Existing
4	Safeguarding	Safeguarding	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			Private Sector	Minimum NHS Contribution	£41,475	Existing
6	Intermediate tier	Intermediate tier	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum NHS Contribution	£1,835,316	Existing
7	Intermediate tier	Intermediate tier	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	Minimum NHS Contribution	£830,665	Existing
8	Single point of access	Single point of access	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Private Sector	Minimum NHS Contribution	£1,138,539	Existing

9	single point of access	single point of access	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Private Sector	Minimum NHS Contribution	£646,385	Existing
10	Community Equipment	Community Equipment	Assistive Technologies and Equipment	Community Based Equipment		Community Health		CCG			NHS Acute Provider	Minimum NHS Contribution	£732,774	Existing
11	Alliance Hospital discharge team	Alliance Hospital discharge team	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Private Sector	Minimum NHS Contribution	£210,487	Existing
12	Community equipment	Community equipment	Assistive Technologies and Equipment	Community Based Equipment		Social Care		LA			NHS Acute Provider	Minimum NHS Contribution	£362,000	Existing
13	Care act duties	Care act duties	Care Act Implementation Related Duties	Other	Includes support for deferred payments and IT	Social Care		LA			Private Sector	Minimum NHS Contribution	£867,783	Existing
14	Care Act Duties	Care Act Duties	Carers Services	Other	Carer advice and support	Social Care		LA			Private Sector	Minimum NHS Contribution	£317,250	Existing
15	Care at home	Care at home	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£86,000	Existing
16	Dementia	Dementia	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			Private Sector	Minimum NHS Contribution	£771,043	Existing
18	7 day working	7 day working	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			Private Sector	Minimum NHS Contribution	£951,858	Existing
19	wider system support	wider system support	Enablers for Integration	Integrated models of provision		Social Care		LA			Private Sector	Minimum NHS Contribution	£457,675	Existing
23	ICP development	ICP development - transformation funding	Enablers for Integration	Other	Transformation Funding	Community Health		CCG			Private Sector	Minimum NHS Contribution	£0	Existing
24	Intermediate tier	Intermediate tier	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			Private Sector	Minimum NHS Contribution	£3,144,715	Existing
25	Intermediate tier	Intermediate tier	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,075,573	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

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'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. 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. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. 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. 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 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 - including small adaptations 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. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. 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. Domiciliary care workforce development 4. 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	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. 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. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible

13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	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.
15	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.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 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	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.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: North East Lincolnshire

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions (per 100,000 population)	Rate per 100,000	263.5	252.2	245.9	278.5	The plan figure will be challenging but there are a number of key workstreams coming in which should help to better manage patients in the community and reduce avoidable admissions. Long term conditions management has been impacted by the pandemic over the last 2	This measure will be monitored monthly using local SUS data to ensure the plan will be achieved. The areas of work that will impact performance on this measure are: •Virtual Ward – although initially this will focus on people discharged from hospital,
	Numerator	420	402	392	444		
	Denominator	159,400	159,400	159,400	159,400		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(See Guidance)	Indicator value	240.8	217.8	195.8	227.4		

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

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	93.9%	93.7%	93.2%	93.5%	There is work on-going to improve performance on this measure. However, the work is only with those going on a pathway 1-3 and the bulk go on pathway 0, therefore this wouldn't dramatically affect the overall improvement on this measure. The plan figure is based on our local data and is slightly higher than achieved in 2021/22 and is based on the work on-going	Work is underway to further promote HomeFirst as the aspiration for all those discharging from hospital. All those were a HomeFirst journey is achieved will improve this indicator
	Numerator	3,182	3,231	3,068	2,936		
	Denominator	3,389	3,447	3,293	3,141		
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
(SUS data - available on the Better Care Exchange)	Quarter (%)	92.5%	92.5%	92.5%	92.5%		
	Numerator	2,960	2,960	2,960	2,960		
	Denominator	3,200	3,200	3,200	3,200		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 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	634.4	626.8	641.6	723.3	The ambition was set based on historical data and the increased pressure on hospital discharge, which when compounded by the community pressure on support at home means that there is likely to be more short term use of	Performance on this measure will be monitored on a monthly basis as part of our Adult Social Care Performance Framework. There continues to be capacity in the residential bed provision and we will continue to support providers
	Numerator	211	212	217	248		
	Denominator	33,258	33,823	33,823	34,289		

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

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 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 (%)	77.3%	80.0%	82.3%	84.0%	We are continually working to improve our re-ablement provision in NEL so aspiring to a stretch target of 84%, the plan figure is based on our historical performance and increased to reflect this stretched target.	This metric is calculated using a 3 month period only, however locally we monitor the measure on a monthly basis to ensure we're on track for the 22-23 Plan figure over those 3 months that the metric uses. We are also ensuring everything that
	Numerator	92	100	93	100		
	Denominator	119	125	113	119		

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

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: North East Lincolnshire

Theme	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
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 ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? 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? 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?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	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 integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • 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 - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. 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.	Narrative plan	Yes			
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • 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?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**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 in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Implementing the BCF policy objectives	**PR6**	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**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? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • 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?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes			
Metrics	**PR8**	**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? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes			

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans 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. The programme is 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).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful definitions and where to go for further support. This sheet provides further guidance on using the Capacity and Demand Template.

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the HWB as part of the wider BCF plan for 2022-23.

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
Data for capacity and demand should be provided on a month by month basis for the third and fourth quarters of 2022-23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in appendix 4 of the BCF Planning Requirements.

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 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 in the relevant sheet or in the guidance tab for readability if required.

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

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:
england.bettercarefundteam@nhs.net
(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.
3. 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. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)
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 uses the pathways set out in the Hospital Discharge and community support guidance -
https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under 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 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

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

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet 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:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

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 level 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 a given time.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:
- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for the whole of 2022-23

- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	North East Lincolnshire
Completed by:	Emma Overton
E-mail:	emmaoverton@nhs.net
Contact number:	0300 3000 662
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Councillr/ Chair of Health and Wellbeing Board
Name:	Stanley Shreeve

How could this template be improved?	Please offer more guidance on the definition of intermediate care

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: North East Lincolnshire

3. Demand

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 uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider 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 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	785	791	806	798	741	796
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	47	47	48	47	44	47
2: Step down beds (D2A pathway 2)	47	47	48	47	44	47
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	65	66	68	66	62	66

Any assumptions made:

The total discharge activity is determined from local SUS data and includes non-elective spells with a length of stay of 1+ days for 18+ population only. This criteria is to assure plans are in line with the data submitted in the daily sitrep by our local providers.

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

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
(Please select Trust/s.....)	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)						
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATI		734	755	763	759	706	758
OTHER		51	36	43	39	35	38
(Please select Trust/s.....)	1: Reablement in a persons own home to support discharge (D2A Pathway 1)						
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATI		44	45	45	45	42	45
OTHER		3	2	3	2	2	2
(Please select Trust/s.....)	2: Step down beds (D2A pathway 2)						
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATI		44	45	45	45	42	45
OTHER		3	2	3	2	2	2
(Please select Trust/s.....)	3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)						
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATI		61	63	64	63	59	63
OTHER		4	3	4	3	3	3

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: North East Lincolnshire

3.2 Demand - Community

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

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	Data from 2021/2022 has been utilised to predict the demand for 2022/23.

Demand - Intermediate Care

Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	46	41	44	54	51	69
Urgent community response	711	627	689	664	591	688
Reablement/support someone to remain at home	70	64	57	70	67	56
Bed based intermediate care (Step up)	15	11	11	12	19	18

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: North East Lincolnshire

4.1 Capacity - discharge

This sheet 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:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

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.

Any assumptions made:	Capacity has been identified using known demand, plus any surplus capacity to forecast for 22/23.

Capacity - Hospital Discharge							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	34	34	34	34	34	34
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	8	8	8	8	8	8
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	61	61	61	61	61	61
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	65	65	65	65	65	65
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	18	18	18	18	18	18

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: North East Lincolnshire

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

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.

Any assumptions made:	Capacity has been identified using known demand, plus any surplus capacity to forecast for 22/23.

Capacity - Community							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	52	52	52	52	52	52
Urgent Community Response	Monthly capacity. Number of new clients.	792	792	792	792	792	792
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	70	70	70	70	70	70
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	20	20	20	20	20	20

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: North East Lincolnshire

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	**9,614,000**
BCF related spend	£7,080,000
Comments if applicable	