DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 9(b)**

DATE	**8 June 2023**
TITLE OF REPORT	**Better Care Fund Plan 2023/25 Approval**
Organisation and Author	**Joint report of the Director of Adult Social Care, Dudley MBC, and the Dudley Managing Director, Black Country Integrated Care Board**
Purpose	**To approve the Better Care Fund (BCF) Plan for Dudley for planning years 2023/2025 in line with the national approval process.**
Background	**Since 2015, the BCF has been crucial in supporting people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person. This vision is underpinned by two core objectives, to:** • **Enable people to stay well, safe, and independent at home for longer.** • **Provide people with the right care, at the right place, at the right time.** **The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under Section 75 of the NHS Act (2006).**
Key Points	**The national planning guidance has been issued for 2023/25 and the required planning documents are due for submission on the 28June 2023.** **Systems are asked to submit a spreadsheet and accompanying documents demonstrating that the BCF national conditions and metrics for 2023/25 are achieved which are:** • **A jointly agreed plan between local health and social care commissioners, signed off by the HWB.** • **Implementation of BCF policy objective 1: enabling people to stay well, safe, and independent at home for longer.**

	• **Implementation of BCF policy objective 2: providing the right care, at the right place, at the right time** • **Maintain the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services.** **Evidence is provided by submitting a planning template which can be found in Appendix 1 and contains:** • **A Strategic narrative plan.** • **Income and Expenditure plan.** • **Demand and Capacity plan.** **This submission will be subject to an NHSE assurance process, and we will update the Board as to the outcome in due course.**
Emerging issues for discussion	**Meeting the conditions and metrics is challenging in today's climate due to:** • **Availability of suitable and affordable workforce** • **Growing number of complex people requiring care and specialist services** • **Demand though our urgent care interface.** **The 2022/23 plan has undergone a light touch review and evaluation to agree items for inclusion for the 2023/25 plan.** **New metrics have been published within the planning guidance. Performance will be reported against those metrics on a regular basis.** **Additional discharge funding has been allocated which sits within the governance framework of the BCF.**
Key asks of the Board/wider system	**Approve the 2023/25 Better Care Fund Plan and authorise the submission of the national planning return based on the enclosed assumptions and indicative plan.**

Contribution to H&WBB key goals: • **Improving school readiness** • **Reducing circulatory disease deaths**	**Improved health outcomes and enhanced wellbeing by using this plan to support:** • **Improving the overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services.**
• **Improving breast cancer screening coverage** **Focus on those neighbourhoods with the greatest need**	• **Tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.**
Contribution to Dudley Vision 2030	**Creating healthy, resilient and safe communities**

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Dudley Health & Wellbeing

Longer, safer, healthier lives for all

DUDLEY HEALTH AND WELLBEING BOARD

DATE 8 June 2023

REPORT OF: Joint report by the Director of Adult Social Care, DMBC and the Managing Director, Black Country Integrated Care Board, Dudley

TITLE: Better Care Fund (BCF) Plan 2023/25 – Approval

PURPOSE OF REPORT:

1. To approve the Dudley Better Care Fund Plan 2023/25.

BACKGROUND

2. Since 2015, the BCF has been crucial in supporting people to live healthy, independent, and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by two core objectives, to:

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

   Provide people with the right care, at the right place, at the right time.

3. The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under Section 75 of the NHS Act (2006). This provides an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

4. The BCF programme underpins key priorities in the NHS Long Term Plan by joining up services in the community and the government's plan for recovering urgent and emergency care (UEC) services, as well as supporting the delivery of Next steps to put People at the Heart of Care. The BCF facilitates the smooth transition of people out of hospital, reduces the chances of re-admission, and supports people to avoid long term residential care. The BCF is also a vehicle for wider joining up of services across health and local government, such as support for unpaid carers, housing support and public health.

5. This submission covers a 2-year period to allow greater certainty to plan the use of BCF funding over a 2-year cycle. The delivery of the BCF will support two key priorities for the health and care system that align with the two existing BCF objectives:

   a. improving overall quality of life for people, and reducing pressure on UEC, acute and social care services through investing in preventative services.

   b. tackling delayed discharge and bringing about sustained improvements in discharge outcomes and wider system flow.

Key Points

6. The BCF national planning conditions for 2023/2025 are:

    - A jointly agreed plan between local health and social care commissioners, signed off by the HWB.
    - Implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer.
    - Implementing BCF policy objective 2: providing the right care, at the right place, at the right time.
    - Maintaining the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services.

7. The BCF Plan must be submitted to the national team by the 28th of June 2023.

Adult Social Care Discharge Fund (ASCDF)

8. On 22 September 2022, the government announced its Plan for Patients. This plan committed £500 million for the remainder of 2022 to 2023 financial year, to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital awaiting social care. Local authorities and ICBs were asked to work together, through their local Health and Wellbeing Boards, to provide plans for spending the funding from the Adult Social Care Discharge Fund (ASCDF – as an addition to existing BCF plans).

9. In Dudley, the ASCDF enhanced the current BCF Plan by providing additional bed-based services and supporting workforce, as well as piloting some additional mental health services though Black Country Healthcare NHS Foundation Trust (BCHC) as the lead provider.

10. In 2023-25 ICBs and Local Authorities have been provided with an additional discharge allocation for continuation of those schemes proven to be successful and are also included within the plan. Although under the governance of the Better Care Fund, these are identified through a separate funding stream.

Finance

11. The finances attached to BCF are outlined in the table below and are made up of several lines:

    - NHS minimum contribution to the BCF
    - Disabled Facilities Grant (DFG)
    - Improved Better Care Fund (iBCF)
    - Adult Social Care Discharge Fund

Table 1: Finances allocated to Better Care Fund

	2022/23 Plan	2022/23 Actual	2023/24 Plan	2024/25 Plan
Disabled Facilities Grant (DFG)	£6,444,209	£6,444,209	£6,444,209	£6,444,209
iBCF Contribution	£16,627,704	£16,627,704	£16,627,704	£16,627,704
Local Authority Additional Contribution	£12,823,162	£12,606,073	£15,560,393	£15,822,293
NHS Minimum Contribution	£26,901,524	£26,901,524	£28,424,150	£30,032,957
Additional ICB Contribution	£1,879,611	£1,504,962	£1,559,524	£1,047,437
Total BCF Pooled Budget	**£64,676,210**	**£64,084,472**	**£62,171,771**	**£69,974,601**
ASC Discharge Fund				
LA Plan Spend	£1,301,350	£1,301,350	£2,331,178	£3,885,297
ICB Plan Spend	£1,512,000	£1,491,356	£1,495,877	£2,791,803
Total ASC Discharge Fund	**£2,813,350**	**£2,792,706**	**£2,331,178**	**£3,885,297**
BCF + Discharge Fund	**£67,489,560**	**£66,877,178**	**£64,502,950**	**£73,859,898**

Not yet confirmed

Planning Process

12. The 2022/23 BCF Plan has undergone a process of review and light touch evaluation which also identified schemes that require more in-depth evaluation to inform the 2023/25 BCF Plan. This was done through a series of stakeholder meetings, with findings presented to the A & E Delivery Board, Urgent Care Operational Group and the Dudley Health and Care Partnership Board.

13. Each scheme was assessed against their contribution to the objectives and priorities outlined within the BCF planning guidance.

14. Following this process, it was agreed that the 2022/23 plan would continue into the 2023/25 plan but four areas were identified as offering opportunities for efficiencies and transformation. These were:

- Palliative Care - opportunity to integrate the Community Palliative Care Service. This may not reduce costs or release resources back into the system; however, this would create a more efficient way of working.
- Redesign of the Discharge Pathway 1 – opportunity to realign a number of services to deliver a more integrated service.
- Step Down Support - medical input into step down facilities provided by The Dudley Group NHS Foundation Trust. This was not utilised due to the closure of the Saltwells care home in April 2022. A potential underspend is available, and consideration will be given as to how it is used.
- Pathway 2 Stepdown Care Physiotherapy – to support intermediate care facilities, there is an opportunity to realign investment from the private sector.

15. Further schemes that meet the criteria for inclusion in the Better Care Fund and funded recurrently through the ICB have also been added to the 2023/25 plan. This includes the Clinical Hub which has a particular role in preventing unnecessary admission to hospital.

METRICS

16. Beyond the four conditions (and grant conditions), areas have flexibility in how the fund is spent across health, care and housing schemes or services, but need to agree ambitions on how this spending will improve performance against the BCF 2023 to 2025 metrics set out below.

Provide people with the right care, at the right place, at the right time.

- In 2023/24: discharge to usual places of residence
- In 2024/25: discharge to usual places of residence, proportion of people discharged who are still at home after 91 days.

Enabling people to stay well, safe, and independent for longer.

- 2023/24: admissions to residential and care homes, unplanned admissions for ambulatory sensitive chronic conditions, the proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services, emergency hospital admissions due to falls in people over 65.

- 2024/25: admissions to residential and nursing homes, unplanned admissions for ambulatory sensitive chronic conditions, outcomes following short-term support to maximise independence.

17. The Business Intelligence (BI) Teams across both the ICB and Local Authority will be working in partnership to agree a reporting schedule against these metrics and the higher cost schemes within the plan. A performance report will be submitted to the Integrated Commissioning Executive.

BCF Plan

18. The BCF plan and narrative plan can be found in Appendix 1. Following approval by this Board and subsequent submission to the national team, BCF plans will be assured and moderated regionally, as well as calibrated across regions. Following this, plans will be put forward for approval by NHSE, in consultation with the Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC).

Recommendations

19. The Board is asked to approve the Dudley Better Care Fund Plan 2023/25.

Appendix 1: # BCF Narrative Plan Template 23-25

Health and Wellbeing Board(s): Dudley

Governance

The assurance and decision-making process for the implementation and continuation of the BCF is the responsibility of the Integrated Commissioning Executive, established through a Section 75 Agreement between Black Country Integrated Care Board and Dudley Metropolitan Borough Council.

Consultation on the plan has been undertaken through an iterative process with Dudley A and E Delivery Board, the Urgent Care Operational Group, and Dudley Health and Care Partnership Board prior to approval by the Health and Well Being Board.

At the beginning of 2023, a programme commenced to review the existing lines of the BCF plan with all stakeholders to inform the 2023/25 programme. For 2023/25, there will be enhanced robust monitoring of the plan throughout the year with areas for further review identified. Evaluations and progress will be governed through the Integrated Commissioning Executive and shared with other stakeholder forums. The development of a revised joint reporting framework is underway which is due to be implemented in July 2023.

Executive summary

Our joint priorities for 2023/25 are: -

- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service
- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embedding the palliative care strategy and its recommendations, alongside the development of a more integrated palliative care team.
- Further developing our Community Partnership Teams
- Exploring opportunities to merge pathways 2 and & 3 to create flexibility around resource and provision.
- Exploring further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in 2023.

Review of 2022/2023 programme

A light touch evaluation took place against the priorities within the 2022/23 plan. The outcome was that most of the investment areas were key in delivering the objectives laid down in the Better Care Fund Guidance, however it identified four areas of opportunity for efficiencies and transformation. An overarching review with comments against all schemes can be found in Appendix 1. The review identified four areas for further transformation work to be undertaken during the next 2 years, as shown in Appendix 2: -

- Transform palliative care services to ensure a truly integrated team across Health and Social care.
- Review of the existing Discharge to Assess Pathways to ensure that these are integrated and represent value for money, to provide D2A/reablement pathways that are the most cost effective and responsive to ensure flow through the urgent care system.
- Review medical cover within the plan for reablement services, particularly those whose function has changed post covid.
- Align rehabilitation investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere.

As we progress through the identified areas of transformation, we intend to make appropriate changes to our existing BCF Plan (Appendix 3). This is to ensure delivery of tangible impacts in line with the vision and objectives set out int the Policy Framework.

The ICB commissioned a review of Discharge to Assess pathways in 2022, and the outcomes from this review will also inform changes to the BCF Plan over the next 12 months. Further areas have also been aligned to the Better Care Fund Plan for 2023/25 where they meet the criteria, these are: -

- Dudley Clinical Hub: This provides an admission avoidance function.
- Handyman investment: To support quick and efficient discharge for those people. with housing issues where a simple intervention can reduce delays.
- Further investment into Discharge to Assess pathways bringing schemes together to ensure the most effective use of resources.

The Adult Social Care Discharge Fund for 2023/25 will continue to enhance current schemes within the existing BCF Plan, notably provision around Pathways 1, 2 and 3.

Dudley Insights

The information below provides an insight into the activity in the Dudley urgent and emergency care system. The data shows that there are significant peaks and troughs in activity and performance in Dudley and winter 2022/23 was particularly challenging.

Figure 1: ED attendances Type 1 at Dudley Group NHS Foundation Trust (DGFT).

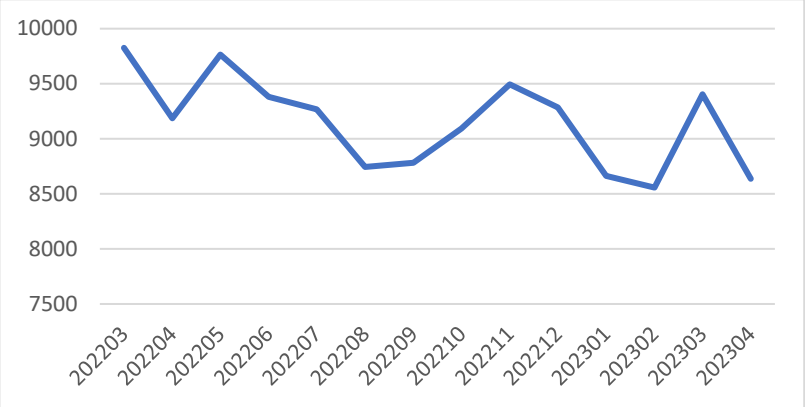


Figure 1 shows that over the last 12months we have seen a general reduction in the number of type 1 attendances at DGFT. We have not had a return to the peak in attendances we saw in March 2022.

Figure 2: Emergency admissions

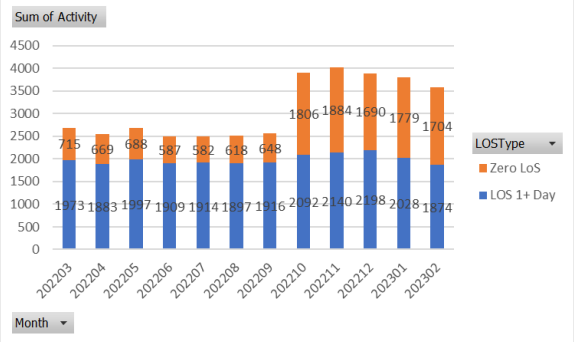
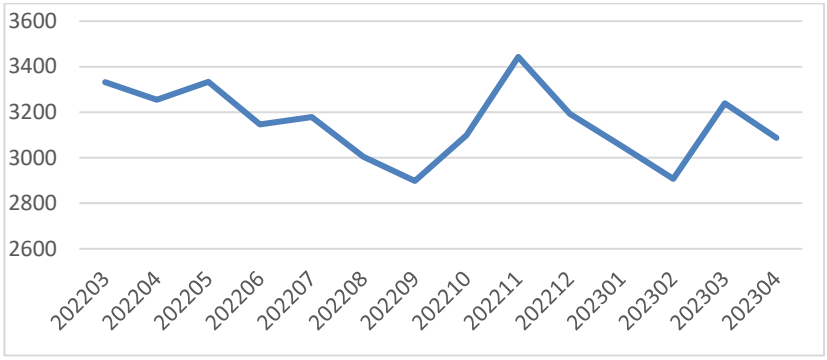


Figure 2 shows a change in activity around September/October of 2022. However, during this period DGFT changed the way Same Day Emergency Care (SDEC) activity was recorded and this is now coded as an emergency admission. The admissions have stayed relatively stable during this period.

Figure 3: Conveyances to DGFT



The admission avoidance activity has increased, and this may be why figure 3 shows a general reduction in ambulance conveyances during the previous 12 months despite the obvious peak during October – December 2022.

Figure 4: Care Home admissions:

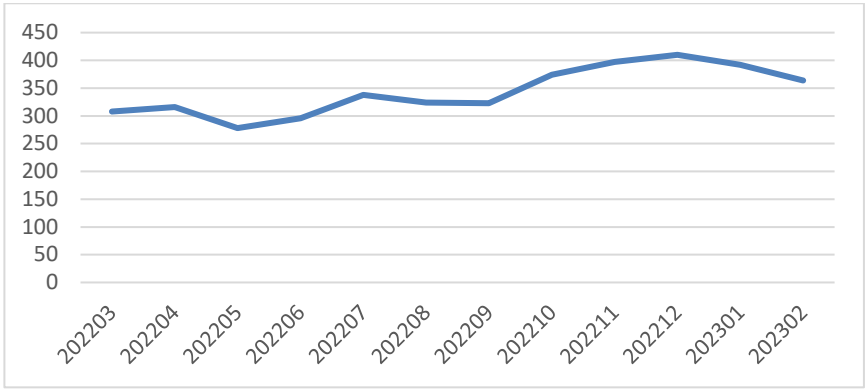
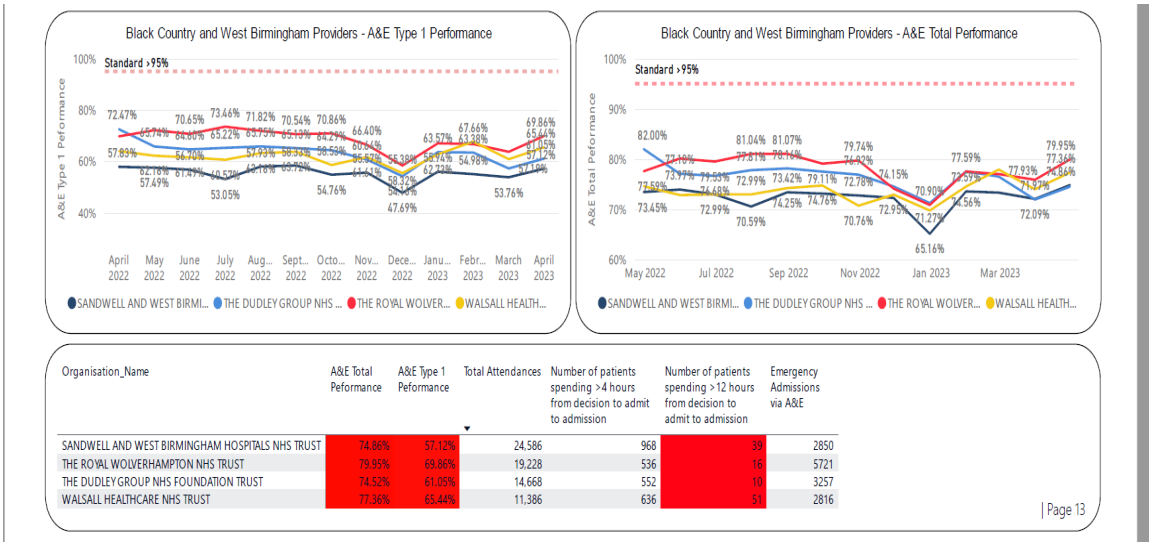


Figure 4 shows that despite an apparent reduction in the curve during recent months, care home admissions are still higher than they were in the same period last year. There is a focused piece of work with care homes working with staff on falls prevention and using appropriate admission avoidance interventions and we hope this will have a significant impact on care home admissions.

Figure 5: System wide A & E type 1 performance.



Organisation_Name	A&E Total Peformance	A&E Type 1 Peformance	Total Attendances	Number of patients spending >4 hours from decision to admit to admission	Number of patients spending >12 hours from decision to admit to admission	Emergency Admissions via A&E
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	74.86%	57.12%	24,586	968	39	2850
THE ROYAL WOLVERHAMPTON NHS TRUST	79.95%	69.86%	19,228	536	16	5721
THE DUDLEY GROUP NHS FOUNDATION TRUST	74.52%	61.05%	14,668	552	10	3257
WALSALL HEALTHCARE NHS TRUST	77.36%	65.44%	11,386	636	51	2816

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Figure 5 shows that Dudley's activity is about average compared to neighbouring places and operates along the same trajectory of demand.

Our current challenges in Dudley are: -

- Too many community beds within Dudley place.
- People within a community bed having a length of stay beyond national guidance.
- Lack of specialist neuro-rehabilitation capacity
- Lack of Pathway 1 domiciliary care capacity.
- People being conveyed to hospital that could be managed through admission avoidance teams.
- Lack of pathway capacity to ensure consistent and smooth flow from an acute bed.

This BCF Plan is intended to respond to these challenges.

National Condition 1:

Overall BCF plan and approach to integration

This plan is designed to support the Dudley health and care system through: _

- Preventing inappropriate admission to hospital, residential or nursing care
- Supporting timely discharge from hospital
- Enabling people to live independent lives in supportive and resilient local communities.
- Reducing wider inequalities by enabling appropriate access to services and embedding preventative measures

Our approach to commissioning is led by the Integrated Commissioning Executive, established under the provisions of a Section 75 Agreement which governs the operation of the Better Care Fund. There is no set approach to joint commissioning, rather a set of approaches based upon what is required to address an issue – singular commissioning by either partner, aligned commissioning where each partner is responsible for their element, joint commissioning where resources are brought together to deliver a joint response.

During the period of our 2022/23 BCF Plan, a number of factors have informed our approach to the 2023/25 BCF Plan: -

- A review of our Discharge to Assess Pathways by an external organisation with a set of recommendations.
- The advent of the Adult Social Care Discharge Fund
- Lessons learned from the winter of 2022/23
- A review of existing BCF schemes

As a result of these specific changes and the challenges we have faced, our priorities for 2023/25 are as follows: -

- Further developing our Community Partnership Teams
- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service
- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embed the palliative care strategy and its recommendations, alongside development of a more integrated palliative care team.
- Explore opportunities to merge pathways 2 and 3 to create flexibility around resource and provision.
- Explore further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in the 2023.

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

Detailed below are some of the main schemes in our approach in Dudley to 'Enabling people to stay well, safe and independent at home for longer.'

Community Partnership Teams

Our Community Partnership Teams are at the heart of our approach to support people at home within supportive local communities. They operate within our six PCNs and bring together clinical and operational staff across primary and community care to wrap higher quality care and services around patients nearer their homes. These teams bring together Community Nursing (District and Long-Term Condition Nurses), Social Care, Voluntary Sector Social Prescribers, Mental Health Nurses as well as the GP Practice and wider PCN workforce, to have a weekly focused discussion around our most complex and vulnerable patients in our community. In the last 10 months a transformation programme has further developed these teams which fundamentally underpin the Integrated Model of Care within Dudley. This has included standardised and dedicated leadership, development of clear metrics and outcomes and the embedding of care co-ordination across primary and secondary care. Currently these teams focus on people with complex comorbidities and frailty, as well as palliative care and complex mental health patients on a monthly basis. We are also expanding the model to have a focus on complex respiratory and diabetes cases. The plan will have strong links with the virtual ward programme as part of the step up/step down pathways of care for frailty, heart failure, respiratory palliative care and care home patients. The Intermediate Care/NHS Continuing Healthcare teams have been further embedded into these Community Partnership Teams to maximise support/rehabilitation to patients within their own home, facilitate timely discharge and support the wider MDTs.

Admission Avoidance

The Clinical Hub provides Dudley with its admission avoidance function through a single point of contact. This service provides the 2-hour community response service triage through to Same Day Emergency Care (SDEC), hospital avoidance to both care homes and people in their own homes, care home educational service and the falls response service. They receive referrals from all stakeholders including primary care, care homes, GPs, social care, and ambulance service. The Urgent Community Response Service (UCR) operates seven days a week 8am-9pm, and the Care Home Educational Team operates 9am-5pm five days a week.

Activity has significantly increased over the latter part of the period. All GP referrals for medical admissions where possible come though this service so that admission avoidance interventions can be put in place if safe to do so.

Figure 6: 2-hour Community Response Activity

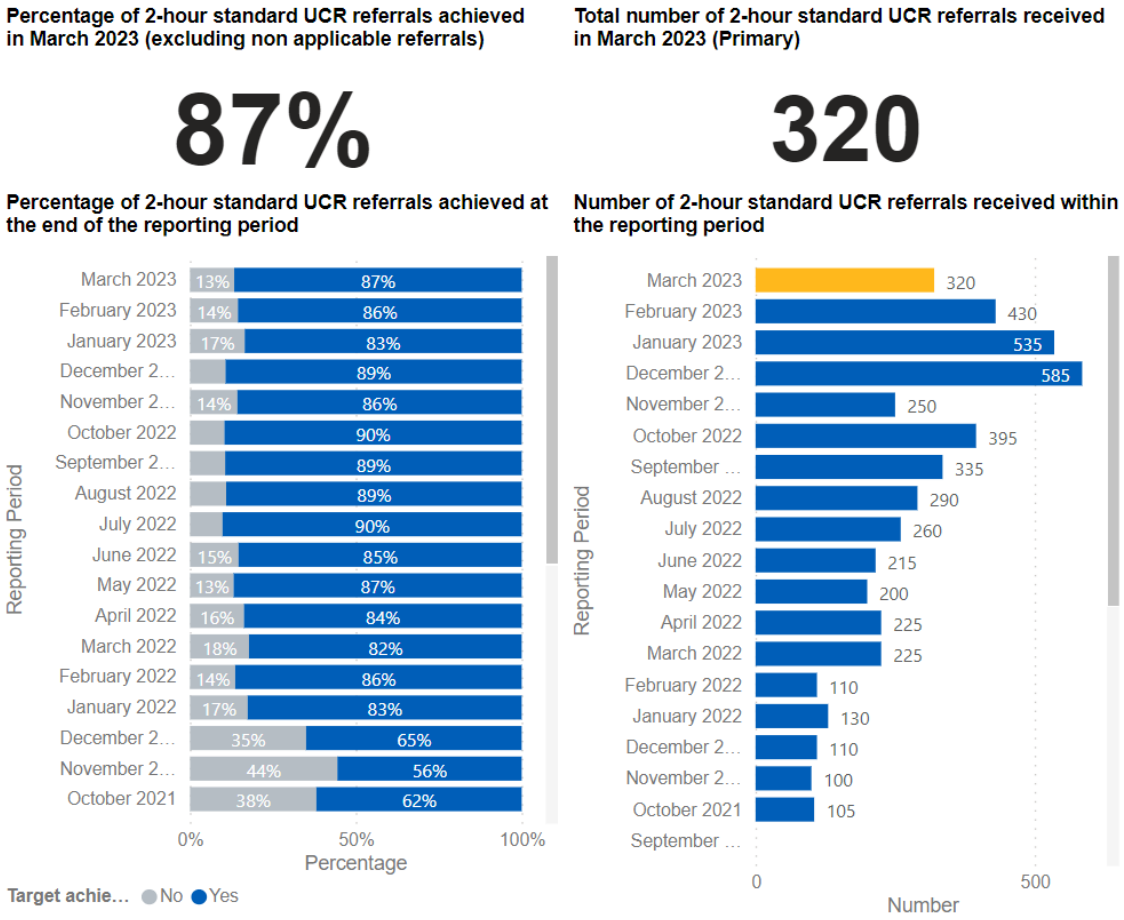


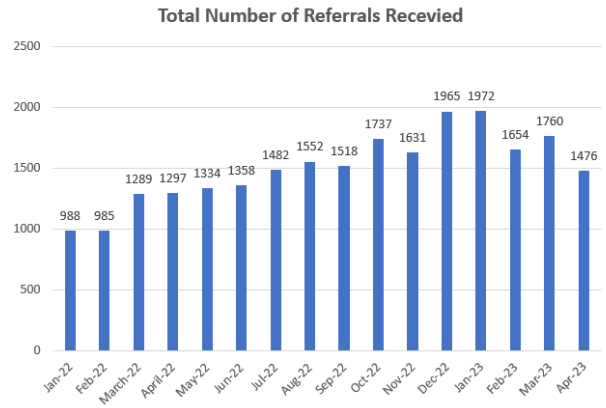
Figure 6 shows that the activity for 2 hour community response has increased over the last 12 months. We will contine to work with the Clinical Hub to ensure that the admisiosn avoidance function is maximised.

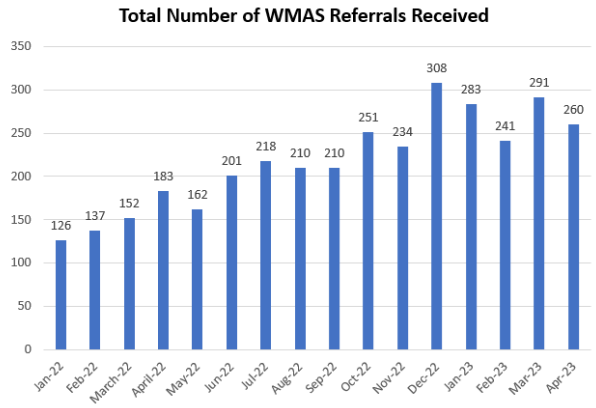
Education and oversight provision is provided for care homes by the Educational Care Home Team, focusing on 21 care homes identified as most in need. This supports care homes to ensure that a patient is not conveyed to hospital unnecessarily and ensures that there is good quality of care delivered within care homes. The Clinical Hub also supports the ongoing Covid – 19 vaccination programme in care homes, and end of life provision. If necessary, the Clinical Hub, will provide carers over night to ensure that people can be cared for within their own environment rather than being admitted to hospital.

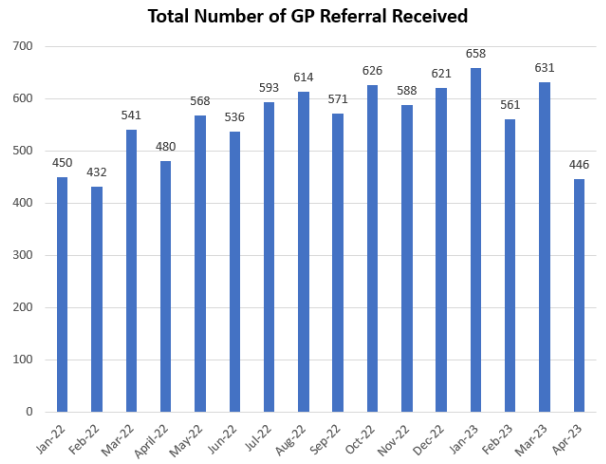
The Falls Service provides a same day response and is available to all care homes within Dudley. The team work with care homes and their residents to respond to the fall but also by providing interventions to prevent future falls. This team has only recently been set up but early data shows that they are reducing ED attendances for this cohort of people by 90%.

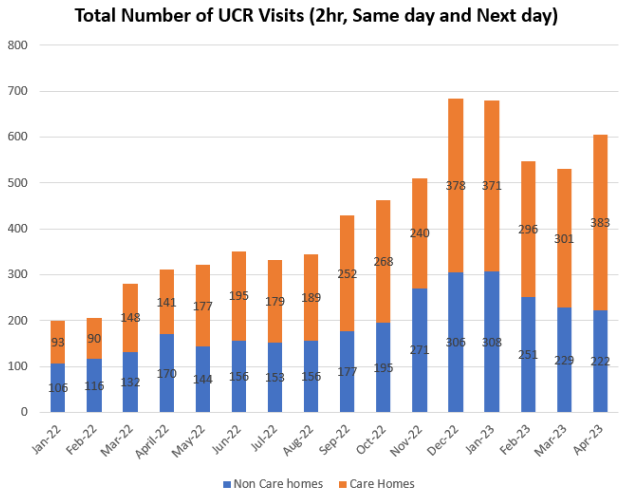
The Hub provides advice, guidance, and treatment around the 9 Core clinical pathways of the Enhanced Health and Care Home model, working in collaboration with the Care Home Education Team.

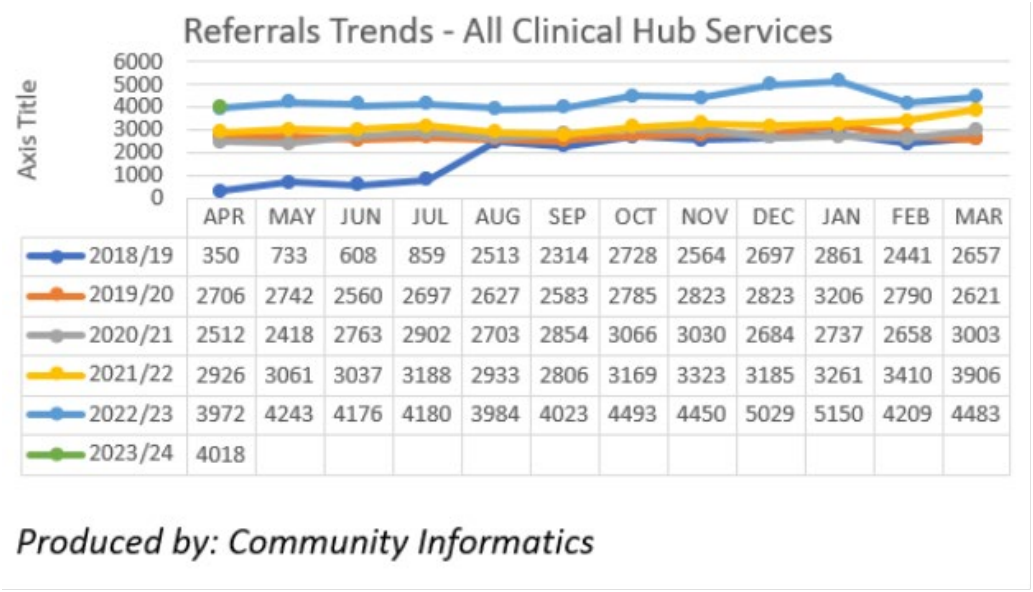
Figure 7 Clinical HUB activity from January 2022 – April 2023: again, showing the general increase in activity over the last 12 months.











	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2018/19	350	733	608	859	2513	2314	2728	2564	2697	2861	2441	2657
2019/20	2706	2742	2560	2697	2627	2583	2785	2823	2823	3206	2790	2621
2020/21	2512	2418	2763	2902	2703	2854	3066	3030	2684	2737	2658	3003
2021/22	2926	3061	3037	3188	2933	2806	3169	3323	3185	3261	3410	3906
2022/23	3972	4243	4176	4180	3984	4023	4493	4450	5029	5150	4209	4483
2023/24	4018											

Admission avoidance functions within the social care community teams offer either step-up facilities or emergency care within a person's own home. Health and social care teams work in collaboration to ensure the person can access the right care at the right time with wrap around support. Where a step-up bed is required, the teams provide the appropriate intervention and support to secure timely discharge back into the community. The hospital avoidance function provides preventative care in the community, signposting is given on direct payments, interventions for falls prevention, administering of personal budgets and health and wellbeing interventions. Reablement is provided by Therapy Services to maximise a person's potential and ensure that desired outcomes are achieved.

Virtual Wards

Dudley Group NHS Foundation Trust lead on the virtual ward programme providing eight virtual wards. The most successful programmes have been respiratory and paediatrics and there is further work required around frailty, and how this links in with the admission avoidance function. The priority so far has been in discharging people from an acute bed to a virtual ward programme, but during the next period the admission avoidance function will be enhanced, so people can be maintained at home, within a virtual ward without entering an acute hospital bed.

Single handed Care

During 2022/23 we piloted a programme of 'single handed care equipment'. This enabled a reduction in the number of carers required to keep people at home and prevent an admission but also facilitated discharge using fewer carers, hence ensuring the capacity of carers was greater. The programme involved training all staff in the use of single-handed equipment, both hospital staff and private providers, as well as a joint commitment to

ensuring this is the default pathway for those people whose needs can be met using this system. Delivery of the equipment can be done at short notice and operates 7 days a week to support admission avoidance and hospital discharge.

Palliative Care Strategy

A palliative care strategy has recently been approved by the Health and Care Partnership Board which commits to developing a system wide approach so that citizens who are in the last stages of their life receive the care they need to preserve their integrity and wellbeing and are as comfortable as possible in the place of their choosing. Providing personalised care planning, shared records and involving the carer in all aspects of care when appropriate. The strategy will be embedded into all discharge plans to ensure that the ambitions of the plan are achieved.

Housing Adaptions

The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering Disabled Facilities Grants (DFGs) funded by the BCF, and public sector adaptations funded by the Council's Housing Revenue Account (HRA). The Home Improvement Team have strong links with both the Council's Adult Social Care team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre-vetted and approved contractors as part of a framework delivery. A handyman programme supports both admission avoidance and discharge, this can be something simple such as lock changing, or furniture movement to something which requires a more substantial adaption or intervention.

Demand and Capacity

Pathway 2 (bedded rehabilitation) capacity and demand modelling has been embedded since the onset of the Covid pandemic and based on work completed through the National Audit for Intermediate Care. Learning from this analysis has highlighted demand trends and where increased capacity is required. Specifically, challenges arise when there are peaks in demand and where a community facility has beds closed due to, for example, infection control issues. Capacity has been used as flexibly as possible to ensure occupancy is maximised and an innovative project providing surge social work capacity funded through the Adult Social Care Discharge Fund (ASCDF) has significantly improved flow in all Discharge to Assess beds.

One area of potential unmet demand for 2023/24 is the gap in local service provision for patients requiring discharge to specialist Neuro-rehabilitation beds. To mitigate this, work is currently ongoing with system partners to develop referral pathways and improved responsiveness to decision making. A dedicated block commissioned specialist resource is being supported to ensure access and reduce delays.

A further issue identified within the last 18 months activity data is the increased number of patients requiring 1:1 support from the acute setting into a Pathway 3 community bed. Further work is being completed in this area to explore if this is a local assessment issue or a developing trend in the acuity of need. Comprehensive reviews of all patients referred with a 1:1 requirement is also being completed.

Pathway 1 capacity has improved during the later part of 2022/23 through ongoing work with the service providers. However, capacity does still not always meet demand. Again, this is challenging during 'peaks,' and capacity may be wasted when discharges are delayed due to reasons beyond Council control.

An implementation plan for a supported hospital discharge team will provide a home first approach to support patients with wrap around care and therapy support. There is ongoing work with DGFT to model the discharges that can be supported within the financial plan and ensure there are no wasted opportunities.

The demand and capacity analysis has highlighted the need to have between 3-5 Discharge to Assess Pathway 1 discharges every day. A priority for Pathway 1 teams in 2023/24 is to further develop links with bed-based intermediate care and community reablement/Own Bed Instead to ensure as many people can be supported in their own home as possible and improve flow through community beds.

Further work will be taking place during the next period to model a process where capacity is available to meet demand but also with partners to facilitate a system where there is a consistent flow of referrals rather than when resource is available within partner organisations.

National Condition 3: Meeting BCF objective2: Provide the right care in the right place at the right time.

We have described above our approach to admission avoidance and how our Community Partnership Teams function. This section will focus on how we deal with timely discharge and flow. Some of the areas previously discussed feature both within the admission avoidance and discharge flow plans, such as the single-handed equipment programme, the application of the palliative care strategy and housing adaptions.

In Dudley data shows that:

- There is on average about a 96% occupancy level of the acute beds.
- There are on average around 100 people at any one time who have been deemed medically fit for discharge, this includes those patients who are waiting for ward actions such as a therapy review.
- About 23% of discharges happen at weekends.
- The majority of those people on the list for meeting the criteria to be discharged are not discharged due to requiring therapy review, followed by a Pathway 1 provision and a small proportion on pathway 2.
- Those delayed on pathway 2 are mainly due to the availability of specialist neuro rehabilitation beds.

Discharge to Assess and Pathways 1,2 & 3.

The Discharge to Assess Policy is now embedded in operational teams with Home First always the starting point for conversations with patients, families and carers around future destination. Own Bed Instead (OBI) dovetails into the discharge pathways with a commitment moving forward to integrate OBI into Pathway 1. Where discharges do not happen and bed days are lost, we have a mechanism in place to record the reasons for this and themes and trends are used to develop a plan for improvement. For example, where one ward has a higher level of failed discharges then there is increased support to understand why, and further interventions are put in place.

There is a working group dedicated to the development of a robust Discharge to Assess programme, collaborating with all partners to ensure that bed days are used in the most effective way and that patients who are suitable enter the D2A programme.

During 2022/23, pathways 2 and 3 were used flexibly to allow for maximisation of capacity dependent on demand. This allowed flow to be maintained by changing the usage of beds in a fluid way dependent upon patient need.

Reablement programme

We have invested in a reablement programme across health and social care. This is a joint programme working across the teams to ensure that those entering pathway 1 on discharge have a robust reablement plan in place. This is a new programme and will be developed further over the coming year.

Home before Lunch

DGFT leads a ‘Home Before Lunch’ project with all partners supporting this principle. Many of the ‘failed’ discharges are due to losing daytime hours and therefore bringing even the most complex discharges out earlier in the day, allows time to facilitate smooth discharges. There is a KPI to ensure that 70% of discharges happen before lunch. On some wards this is being achieved and on other wards further work is required to improve their performance against this KPI.

System Developments

As a place we have bespoke schemes and programmes to meet the needs of our local population, however as Dudley is part of a wider Integrated Care System (ICS), we also look at opportunities to work at scale. For example, within the Black Country ICS the Adult Social Care Discharge Fund has been used to commission system wide schemes from Black Country Healthcare NHS Foundation Trust – the lead provider for mental health, learning disability and autism services. This includes providing housing support and a social prescribing service for mental health inpatients. During the next term, we will continue to look at opportunities to commission at scale where this makes sense.

Discharge HUB

There is currently a virtual Discharge HUB in Dudley with partners meeting several times during the day to discuss discharge pathways and the no criteria to reside lists, to ensure the maximum number of complex discharges are achieved. All teams use an integrated discharge database to manage discharges and ensure smooth lines of communication with all teams. Further work will take place during the next period to enhance how this database can accurately reflect discharge positions in real time.

In line with the NHSE targets for UEC discharge HUB developments we will continue to develop this team to ensure we are maximising its capability. A recently commissioned Integrated Brokerage Team, staffed through a collaborative model across organisations, delivers an integrated response to discharge into a bed-based service. This has functioned particularly well and allows people to naturally move from one pathway to another in a seamless manner if their needs change.

Handyman Programme

This was funded through the winter of 2022/23, and we will look to continue this programme during the next period. This was an excellent example of using a simple intervention to release acute bed days by using a personalised approach to discharge planning. For example, if a person had lost their keys, required house cleansing etc, the handyman programme was utilised to provide this personalised intervention to facilitate discharge.

High Impact Change Model

The High Impact Change Model has been reviewed for this financial year. A summary of the findings and opportunities for further development are detailed below. This table provides the key themes from the high impact assessment and identified key areas for development in the coming term. These areas focus on:

- Home for lunch.
- Development of the Integrated Discharge HUB.
- Better discharges to care homes.
- Improved BI system.
- Home First approach.

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	Some wards achieving KPI of home for lunch	Bring decision making to earlier in the day.	September 2023	Percentage increase of home for lunch
Change 2: Monitoring and responding to system demand and capacity	Dudley place has a system for monitoring demand and capacity but does not align with system partners.	Further negotiation with system partners to align system and criteria for reporting.	July 2023	All criteria across the system for reporting demand and capacity is consistent.
Change 3: Multi-disciplinary working	Good MDT working although further work to develop the discharge HUB	Benchmark current practice against standards and develop a plan for improvement.	Benchmarking has begun, action plan will be developed by August 2023.	Meet the UEC standards for an integrated discharge hub
Change 4: Home first	Dependent on ward and area of discharge, depends on home first approach.	Work with acute colleagues on messaging and upskilling discharge conversations	September 2023	Default conversation for all discharges is 'Home first'
Change 5: Flexible working patterns	Flexible approach			

Change 6: Trusted assessment	In place			
Change 7: Engagement and choice	In place			
Change 8: Improved discharge to care homes	Performance is varied.	Work with acute colleagues and the care hone sector to agree what 'good' looks like. An existing work programme is in place to take this forward.	September 2023	No incidents reported from care homes for poor discharges.
Change 9: Housing and related services	Issues arise with complex discharges in housing related matters	Ensure housing and acute colleagues develop pathways and communication channels. This work has begun.	October 2023	For discharges that require housing interventions to be smooth and zero 'wasted' bed days.

How we support unpaid carers

BCF funding is used to fund the Carers Hub and Wellbeing Service. This is delivered by the Council's Carers Network Team and a commissioned provider, providing information, advice and support including peer support, welfare benefits advice and applications, young adult carers mentoring service (18 – 25), carers assessments and a preventative carer sitting service. Funding is used to ensure support is provided for the person receiving care at home. This includes support with social worker capacity to undertake Care Act compliant assessments.

The service operates from two HUBs, one in the south and one in the north of the borough. •In 2022/23 the service engaged with approximately 3,500 carers.400 carers were referred for direct support to the Adult Carer Wellbeing Service They offer a range of services including: -

- Community-based delivery such as in local parks and libraries.
- Welfare benefits/allowance advice – supported new claims/appeals, raising £1,129,317.
- Peer Support – groups and activities
- Carers Rights and Awareness Sessions
- Young Adult Carer (18-25) Service.

The Hub delivered: -

- 244 Carers Assessments and 158 Carers Reviews.
- 113 Carers direct payments (via carers assessment) to support carers' health and wellbeing with a value £33,500.
- Provision of short-term preventative sitting service for carers. This service will be included as part of the commissioning of the Adult Carers Wellbeing Service, to ensure it meets the current needs of carers.
- Support with 'cost of living' via Household Support Fund (HSF) payments to carers
- 1,200 carers aged 65 or above received a £150 voucher and 1,800 carers aged 18 – 64 received a £50 voucher.

Following its success, this service has extended a pilot digital carers service. The digital support targets the wider carer community who may not wish to access direct support from the Hub or need support outside of normal working hours. This includes information, advice, virtual chat, and peer group meetings.

Since the start of the pilot the service has achieved 19,751 hits to its website with 67% of this outside of normal working hours, ensuring support is available 24/7. In addition, it has engaged 2,306 carers and directly supported 641 carers.

Based on the success of the pilot, we plan to include a 'digital offer' within the next Carers Wellbeing Service tender. We are also continuing to work with ADASS Regional Carers to look at a possible regional digital offer for carers.

We are continuing to work with DGFT to establish a jointly funded Carers Information Hub within the hospital, to identify and support local carers. It is anticipated that this will open in summer 2023.

The Careers Strategy and Action Plan is currently being reviewed and refreshed, consultation and engagement with local carer organisations and groups has taken place with feedback now informing key priorities for the next strategy (2023 – 2026).

Following a review of the service and consultation with carers, the Adult and Young Carers Wellbeing Service will be recommissioned with services to commence from Autumn 2023.

Disabled Facilities Grant (DFG) and wider services

Dudley Council has a published its commitment to deliver DFGs for its residents. The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering DFGs funded by the BCF, and public sector adaptations funded by the Council's Housing Revenue Account (HRA). The Home Improvement Team has strong

links with both the Council's Adult Social Care Team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre-vetted and approved contractors.

There is a joint Housing, Communities and Social Care Action Plan, currently under review, to monitor and improve the service provided, with a particular focus on waiting times. There is a current Council policy for DFGs, which provides for discretion in awarding grants, incorporated into the latest Housing Assistance and Guidance Policy.

A revised Housing Assistance and Guidance Policy has now been approved following the publication of the Disabled Facilities Grant (DFG): Guidance for Local Authorities in England to ensure that the Council continues the work that has already been undertaken to develop a service to ensure flexibility of grant delivery that enables people to stay well, safe, and independent at home for longer.

Flexible use of resource has already enabled a less bureaucratic means test of resources and assisted in providing minor adaptations, hoisting equipment, and helping people to re-locate to more adaptable homes. For example, we have invested:

- £695,000 towards additional Community Equipment Service equipment for prescribers across the health and care economy to support people to maximise their independence, including bathing equipment, specialist chairs, mobility aids and hoists.
- £47,000 towards the Handyman Service for the capital expenditure on key safes and ironmongery, safety, security, and small adaptations

In future, increasing the flexibility of the grant further will enable more heating and energy saving support to be provided, help for children living in joint residency, closer working with other housing providers and a contribution to other projects.

How is Dudley Tackling Health Inequalities

Tackling inequalities in health and wellbeing is one of the overarching purposes of integration. Each new or existing service funded by the BCF or IBCF must have regard to the need to reduce inequalities in access to health and care and improve health and wellbeing outcomes.

Dudley's approach to health inequalities is based upon addressing the three pillars of access, prevention and the wider determinants of health and wellbeing. This forms the focus of activity for all partnership bodies led by the Health and Wellbeing Board's Joint Health, Wellbeing, and Inequalities Strategy.

The Health and Care Partnership Board has jointly agreed to an evidence-based Outcomes Framework that lies at the heart of our approach to Population Health Management. A Population Health Management and Inequalities Group reports to the Health and Wellbeing Board and co-ordinates this work across partners.

There has been significant learning since the last plan around health inequalities, and how these impact on both health maintenance and prevention. Whilst the overall uptake rate is the highest in the Black Country, Covid vaccine take-up has been significantly lower in some population groups in Dudley, and these populations are at higher risk of hospital admission. This continues to be an area of focus and the lessons learned in understanding the reasons behind “vaccine hesitancy” have an impact on how we can ensure wider access issues are addressed.

Part of our approach to addressing health inequalities is the creation of strong and resilient communities through our work with the voluntary and community sector. This has included investment in community led projects to address inequalities, including support for carers. These schemes will be reviewed in 2023/24 and the ICB will seek to fund sustainably if evaluations prove positive.

Dudley Council for Voluntary Service – the local umbrella body for voluntary and community sector organisations – is a key partner. As well as providing our local High Intensity User Service, their Integrated Plus workers are embedded within our Community Partnership Teams and work to support the discharge and admission avoidance processes, through the facilitation of effective social prescribing interventions to avoid the medicalisation of problems.

Appendix 1: Evaluation of Better Care Fund 2022-2023

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Tissue Viability Service - Assistive Technologies and Equipment	✓	✓	✓	✗	✓
Intermediate Care Team - District Nursing	✓	✓	✓	✗	✓
Step down - Occupational Therapy provided by DGFT		✓	✓	✗	✓
Step down - Physiotherapy provided by DGFT		✓	✓	💡	✓
LTC Nurses	✓	✓	✓	✗	✓
Own Bed Instead	✓	✓		✗	✓
Medical Cover into Intermediate Care Intermediate Care Support - Dr Plant		✓	✓	✗	✓

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Admission Avoidance Service – Beds Intermediate/ Stepdown Care - GP Respite	✓	✓	✓	✗	✓
Nursing Home Beds Intermediate/ Stepdown Care		✓	✓	✗	✓
Nursing Home Beds Pathway 3 Beds		✓	✓	✗	✓
Nursing Home Beds Intermediate/ Stepdown Care		✓	✓	✗	✓
Joint **Palliative Care** Support Team	✓	✓	✓	💡	✓

BCF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign	To continue into 23-24
Intermediate/ Stepdown Care - Physiotherapists		✓	✓		✓
Medical Cover - Saltwells Stepdown Cover – DGFT		✓	✓		✓
Highest Care Needs – coordinated palliative care community-based and inpatient care	✓	✓	✓		✓
Reablement Highest Care Needs – coordinated community-based and inpatient care	✓	✓	✓		✓

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Enhanced neuro-rehabilitation capacity		✓	✓	✗
Additional Intermediate Care bed-based capacity		✓	✓	✗
Social work capacity		✓	✓	✗
Discharge to Assess – enhance model		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Therapy capacity for pathway 3 and spot purchase beds	✓	✓	✓	✗
Bridging beds		✓	✓	✗
Assessment capacity to review care packages in peoples own homes.	✓	✓	✓	✗
Therapy support in patents own homes	✓	✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional social work capacity for mental health and LD patients		✓	✓	✗
Additional equipment	✓	✓	✓	✗
Overtime for DOM care workers and social work staff	✓	✓	✓	✗
Additional Pathway 3 beds		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional Pathway 1		✓	✓	✗
Additional back-office support	✓	✓	✓	✗
Administration time for planning and co-ordination	✓	✓	✓	✗
Additional Intermediate Care Nurse capacity		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Additional discharge 2 Assess joint plan (townships)	✓	✓	✓	
Support for pathway 0		✓	✓	✗
Top slice for administration	✓	✓	✓	✗
Additional beds to support discharge for those patients testing positive for covid		✓	✓	✗

ASC DF 22-23 Schemes

Scheme Name	Admission Avoidance	Supports Timely Discharge	Provides Care in the Most Appropriate Setting	Opportunity to Decommission / Redesign
Voluntary sector support for mental health inpatients	✓	✓	✓	✗
Additional pathway 3 beds managed by health teams, patients with nursing needs		✓	✓	✗

Appendix 2 - BCF 23-24 Work Plan

4 areas for review	Q1	Q2	Q3	Q4
Transform **Palliative Care Services** to ensure a true integrated team across Health and Social care.	Set up Dudley Place Palliative Care Integration Working Group. Establish core members and develop TOR	Working group to explore opportunities and potential solutions for integration	Continue to collaborate to coproduce recommendations	Recommendations to be presented to the Integrated Care Executive
Review of the existing **Discharge to Assess Pathways**, ensuring integration, value for money and ensure patient flow.	D2A Steering Group established and in place. Need to determine action plan and timelines.	Continuation of D2A Steering Group and implementation of Action Plan.	Continue to collaborate to coproduce recommendations	Continue to collaborate to coproduce recommendations
Review **medical cover** within the plan for int care services, particularly those whose function has changed post covid.	Not a priority for Q1	Review current position and recommendations taken to Integrated Commissioning Executive.	Implementation of recommendations	Complete
Align rehabilitation **(Step down physiotherapy)** investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere.	Not a priority for Q1	Discussion with existing provider to identify opportunities	Implementation	Complete

Appendix 3: Planning Template

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Ian	Bevan	Cllr.Ian.Bevan@dudleymbc.org.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Mark	Axcell	m.axcell@nhs.net
	Additional ICB(s) contacts if relevant	Mr	Neill	Bucktin	neill.buctin@nhs.net
	Local Authority Chief Executive	Mr	Kevin	O'Keefe	kevin.okeefe@dudley.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Matt	Bowsher	matt.bowsher@dudley.gov.uk
	Better Care Fund Lead Official	Mr	Neill	Bucktin	neill.buctin@nhs.net
	LA Section 151 Officer	Mr	Iain	Newman	iain.newman@dudley.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 --\>	Local Authority Senior Principal Accountant	Mr	Tom	Huntbatch	thomas.huntbatch@dudley.gov.uk

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£6,444,209	£6,444,209	£6,444,209	£6,444,209	£0
Minimum NHS Contribution	£28,424,150	£30,032,957	£28,424,150	£30,032,957	£0
iBCF	£16,627,704	£16,627,704	£16,627,704	£16,627,704	£0
Additional LA Contribution	£15,560,393	£15,822,293	£15,560,393	£15,822,293	£0
Additional ICB Contribution	£1,559,524	£1,047,437	£1,559,524	£1,047,437	£0
Local Authority Discharge Funding	£2,331,178	£3,885,297	£2,331,178	£3,885,297	£0
ICB Discharge Funding	£1,495,877	£2,791,802	£1,495,877	£2,791,802	£0
Total	**£72,443,036**	**£76,651,699**	**£72,443,035**	**£76,651,699**	**£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,077,338	£8,534,515
Planned spend	£9,794,427	£10,385,991

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£17,879,723	£18,891,716
Planned spend	£17,879,723	£18,891,716

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	889.0	915.0	940.0	965.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,874.0	2,108.8
	Count	1268	1427
	Population	66258	66258

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	90.8%	90.5%	90.7%	90.9%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	789	798

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.0%

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

3.1 Demand - Hospital Discharge

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

Trust Referral Source (Select as many as need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Social support (including VCS) (pathway 0)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Reablement at home (pathway 1)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST													
THE DUDLEY GROUP NHS FOUNDATION TRUST		168	175	140	137	149	148	175	171	159	216	150	176
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Rehabilitation at home (pathway 1)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Short term domiciliary care (pathway 1)												
THE DUDLEY GROUP NHS FOUNDATION TRUST													
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Reablement in a bedded setting (pathway 2)												
THE DUDLEY GROUP NHS FOUNDATION TRUST		13	12	10	11	10	14	12	10	13	15	14	12
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Rehabilitation in a bedded setting (pathway 2)												
THE DUDLEY GROUP NHS FOUNDATION TRUST		48	32	38	37	38	42	40	43	45	55	50	42
DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST	Short-term residentialnursing care for someone likely to require a longer-term care home placement (pathway 3)												
THE DUDLEY GROUP NHS FOUNDATION TRUST		55	72	66	61	63	63	77	70	68	63	50	52
Totals	**Total:**	284	291	254	246	260	267	304	294	285	349	264	282

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)												
Urgent Community Response	97	80	84	83	55	84	72	83	98	113	86	113
Reablement at home	168	175	140	137	149	148	175	171	159	216	150	176
Rehabilitation at home												
Reablement in a bedded setting	55	72	66	61	63	63	77	70	68	63	50	52
Rehabilitation in a bedded setting												
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Reablement at Home	Monthly capacity. Number of new clients.	175	175	175	175	175	175	175	175	175	175	175	175
Rehabilitation at home	Monthly capacity. Number of new clients.												
Short term domiciliary care	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	65	65	65	65	65	65	65	65	65	65	65	65

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Urgent Community Response	Monthly capacity. Number of new clients.	100	100	100	100	100	100	100	100	100	100	100	100
Reablement at Home	Monthly capacity. Number of new clients.												
Rehabilitation at home	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Other short-term social care	Monthly capacity. Number of new clients.												

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Dudley

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Dudley	£6,444,209	£6,444,209	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£6,444,209**	**£6,444,209**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Dudley	£2,331,178	£3,885,297	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Black Country ICB	£1,495,877	£2,791,802	Yes
Total ICB Discharge Fund Contribution	£1,495,877	£2,791,802	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Dudley	£16,627,704	£16,627,704	Yes
Total iBCF Contribution	**£16,627,704**	**£16,627,704**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
Dudley	£15,560,393	£15,822,293	Minimal uplift included for 24/25, will be revised as part	Yes
Total Additional Local Authority Contribution	**£15,560,393**	**£15,822,293**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Black Country ICB	£28,424,150	£30,032,957
Total NHS Minimum Contribution	**£28,424,150**	**£30,032,957**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
NHS Black Country ICB	£1,559,524	£1,047,437	Uplift applied for 24/25, will be reviewed as part of	Yes
Total Additional NHS Contribution	**£1,559,524**	**£1,047,437**		
Total NHS Contribution	**£29,983,674**	**£31,080,394**		

	2023-24	2024-25
Total BCF Pooled Budget	**£72,443,036**	**£76,651,699**

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Dudley

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£6,444,209	£6,444,209	£0	£6,444,209	£6,444,209	£0
Minimum NHS Contribution	£28,424,150	£28,424,150	£0	£30,032,957	£30,032,957	£0
iBCF	£16,627,704	£16,627,704	£0	£16,627,704	£16,627,704	£0
Additional LA Contribution	£15,560,393	£15,560,393	£0	£15,822,293	£15,822,293	£0
Additional NHS Contribution	£1,559,524	£1,559,524	£0	£1,047,437	£1,047,437	£0
Local Authority Discharge Funding	£2,331,178	£2,331,178	£0	£3,885,297	£3,885,297	£0
ICB Discharge Funding	£1,495,877	£1,495,877		£2,791,802	£2,791,802	£0
Total	**£72,443,036**	**£72,443,035**	**£1**	**£76,651,699**	**£76,651,699**	**£0**

Required Spend

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

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,077,338	£9,794,427	£0	£8,534,515	£10,385,991	£0
Adult Social Care services spend from the minimum ICB allocations	£17,879,723	£17,879,723	£0	£18,891,716	£18,891,716	£0

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1001	Whole Population Prevention / Population Health Management	Locality Based Prevention Hubs	Community Based Schemes	Integrated neighbourhood services					Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£1,299,140	£1,299,140	
1001	Whole Population Prevention / Population Health Management	Locality Based Prevention Hubs - Carer support	Carers Services	Other	Locality Based Prevention Hubs - Carer support			Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	Existing	£434,900	£434,900	
1002	Whole Population Prevention / Population Health Management	Community Equipment Stores	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£520,300	£527,100	
1002	Whole Population Prevention / Population Health Management	Community Equipment Stores	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£616,300	£624,300	
1003	Whole Population Prevention / Population Health Management	Disabled Facilities Grant	DFG Related Schemes	Other	Disabled Facilities Grant			Number of adaptations funded/people supported	Social Care		LA			Local Authority	DFG	Existing	£6,444,209	£6,444,209	
1004	Whole Population Prevention / Population Health Management	Falls Service	Prevention / Early Intervention	Other	Falls service				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£54,200	£58,400	
1005	Whole Population Prevention / Population Health Management	Careres Network Team	Carers Services	Other	Carer Advice and Support			Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£219,400	£223,400	
2001	Urgent Care Needs – Integrated Access & Rapid Response	Out of Hours	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£200,400	£204,200	
2001	Urgent Care Needs – Integrated Access & Rapid Response	Out of Hours	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£34,200	£34,800	
2002	Urgent Care Needs – Integrated Access & Rapid Response	Access - SPOA	Integrated Care Planning and Navigation	Support for implementation of anticipatory care					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£1,691,900	£1,819,400	
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£7,083,923	£7,762,816	
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	IBCF	Existing	£6,426,513	£6,426,513	
3001	Ongoing Care Needs - Enhanced Primary & Community Care	Homecare	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£1,638,664	£1,638,664	
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£147,300	£155,600	
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Personalised Budgeting and Commissioning						Social Care		LA			Private Sector	Additional LA Contribution	Existing	£3,582,900	£3,582,900	
3003	Ongoing Care Needs - Enhanced Primary & Community Care	Direct Payments	Carers Services	Respite services				Beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£89,100	£89,100	
3004	Ongoing Care Needs - Enhanced Primary & Community Care	Urgent care assessment and therapy	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£936,450	£965,150	
3004	Ongoing Care Needs - Enhanced Primary & Community Care	Urgent care assessment and therapy	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Additional LA Contribution	Existing	£936,450	£965,150	
4001	Highest Care Needs – coordinated community-based and inpatient care	Living independentley Team - Community Reablement	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£724,400	£738,500	
4001	Highest Care Needs – coordinated community-based and inpatient care	Living independentley Team - Community Reablement	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Additional LA Contribution	Existing	£790,300	£809,600	
4002	Highest Care Needs – coordinated community-based and inpatient care	Access & Prevention - Occupational Therapy	Prevention / Early Intervention	Other	Assessment for adaptations and preventative				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£228,100	£232,700	
4002	Highest Care Needs – coordinated community-based and inpatient care	Access & Prevention - Occupational Therapy	Prevention / Early Intervention	Other	Assessment for adaptations and preventative				Social Care		LA			Local Authority	Additional LA Contribution	Existing	£1,002,400	£1,022,800	
4003	Highest Care Needs – coordinated community-based and inpatient care	Tiled House	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)				Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,983,600	£3,031,600	
4004	Highest Care Needs – coordinated community-based and inpatient care	External reablement - packages of care	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£2,235,600	£2,362,100	
4004	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care - Homecare assistants	Urgent Community Response						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£536,900	£541,800	
4004	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care - Homecare assistants	Urgent Community Response						Social Care		LA			Local Authority	Additional LA Contribution	Existing	£931,800	£956,300	
4005	Highest Care Needs – coordinated community-based and inpatient care	Palliative - front end	Personalised Care at Home	Other	Palliative Care				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£272,000	£277,400	
4006	Highest Care Needs – coordinated community-based and inpatient care	Supported Living - MH	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£246,100	£260,000	
4006	Highest Care Needs – coordinated community-based and inpatient care	Supported Living - MH	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Additional LA Contribution	Existing	£1,610,789	£1,610,789	
4007	Highest Care Needs – coordinated community-based and inpatient care	Integrated Discharge Pathway	High Impact Change Model for Managing Transfer of Care	Other	Bed based Packages				Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£1,063,600	£1,123,800	
4007	Highest Care Needs – coordinated community-based and inpatient care	Short Term beds	Bed based intermediate Care Services (Reablement,	Other	Discharge 2 Assess			Number of Placements	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£204,300	£215,900	
4007	Highest Care Needs – coordinated community-based and inpatient care	Short term beds	Bed based intermediate Care Services (Reablement,	Other	Discharge 2 Assess			Number of Placements	Social Care		LA			Private Sector	IBCF	Existing	£488,901	£488,901	
4008	Highest Care Needs – coordinated community-based and inpatient care	Internal Day Care & Dementia Gateways	Community Based Schemes	Other	Internal Day Care & Dementia				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,124,700	£1,145,700	
4009	Highest Care Needs – coordinated community-based and inpatient care	Urgent Care enhanced offer	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	IBCF	Existing	£1,001,300	£1,001,300	
4010	Highest Care Needs – coordinated community-based and inpatient care	Enhanced therapy offer	Home-based intermediate care services	Other	Preventing admissions to acute setting			Packages	Social Care		LA			Local Authority	IBCF	Existing	£998,700	£998,700	
4011	Highest Care Needs – coordinated community-based and inpatient care	Enhanced review offer	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	IBCF	Existing	£216,100	£216,100	
4012	Highest Care Needs – coordinated community-based and inpatient care	Bed based Packages	Integrated Care Planning and Navigation	Other	Bed based Packages				Social Care		LA			Private Sector	IBCF	Existing	£5,934,569	£5,934,569	
4013	Highest Care Needs – coordinated community-based and inpatient care	DDS clients over 65	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	IBCF	Existing	£1,561,621	£1,561,621	
5001	Discharge to Assess	Enhance the discharge to Assess model and increase capacity	Home Care or Domiciliary Care	Domiciliary care packages				Hours of care	Social Care		LA			Private Sector	Local Authority Discharge Funding	Existing	£732,164	£732,164	
5001	Discharge to Assess	Enhance the discharge to Assess model	Home-based intermediate care services	Reablement at home (accepting step up and step down users)				Packages	Social Care		LA			Local Authority	Local Authority Discharge Funding	New	£1,000,000	£2,554,119	
5002	Additional Pathway 3 beds	To support discharge to assess to ensure that patients are transferred from hospital to an appropriate	Residential Placements	Short-term residential/nursing care for someone likely to require a					Social Care		LA			Private Sector	Local Authority Discharge Funding	Existing	£262,718	£262,718	
5003	Additional equipment	To reduce the number of resource for pathway 1 we require additional equipment for the single handed	Assistive Technologies and Equipment	Community based equipment				Number of beneficiaries	Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£200,000	£200,000	
5004	Additional social work capacity for mental health and LD colleagues	Dedicated SW support for this cohort, recruitment commenced for 2 WTE	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Local Authority Discharge Funding	Existing	£136,296	£136,296	

232501	Tissue Viability Service	Provision of equipment to enable discharge of patients to their own home, mattresses/beds etc. (Drive	Assistive Technologies and Equipment	Community based equipment		1550	1750	Number of beneficiaries	Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,255,165	£1,263,951
232502	Clinical Hub	2 Hour Response and Admission Avoidance Service	Urgent Community Response						Community Health		NHS			NHS	Additional NHS Contribution	Existing	£598,701	£602,892
232503	Palliative and End of Life Care – dedicated Domiciliary Care Teams	Dedicated Domiciliary Care providing end of life care to people in own homes	Community Based Schemes	Other					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£1,955,912	£1,969,604
232504	Own Bed Instead (OBI)	OBI is a rehab service to support people in their own homes	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£485,391	£488,789
232505	Long Term Conditions Nurses - Hospital Avoidance Team	Long Term Conditions Nurses (Hospital Avoidance Team)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£252,080	£253,845
232506	Pathway 2 Beds	Block Pathway 2 Capacity Intermediate/ Stepdown Care	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,907,934	£2,444,293
232507	Additional Pathway 2 Beds capacity (ASCDF - Line 1 and 2)	Awaiting confirmation of ASDCF, finance to be agreed.	Residential Placements						Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£280,000	£400,000
232508	Pathway 3 Beds	Block Pathway 3 beds	Bed based intermediate Care Services (Reablement,	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,093,476	£1,101,130
232509	Pathway 2 Neuro Rehab Beds		Bed based intermediate Care Services (Reablement,						Community Health					Private Sector	Minimum NHS Contribution	Existing	£750,000	£755,250
232510	Pathway 2 Neuro Rehab Beds ASCDF	Awaiting confirmation, finance to be agreed	Bed based intermediate Care Services (Reablement,						Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£100,000	£150,000
232511	Intermediate Care Admision Avoidance Beds	Intermediate Care Admission Avoidance beds	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£1,632,835	£1,644,265
232512	District Nursing support into Intermediate Care	District Nursing support into Intermediate Care based at Tiled House. (Provider - DGFT)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£231,166	£232,784
232513	Additional Social Work Capacity (ASCDF Line 3)	Awaiting confirmation of ASDCF, finance to be agreed.	Community Based Schemes						Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£120,000	£150,000
232514	Extra Intermediate Care Nurse capacity to support Pathway 2 (Line 16 ASCDF)	Awaiting confirmation of ASDCF, finance to be agreed.	Community Based Schemes	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			Private Sector	ICB Discharge Funding	New	£30,000	£40,000
232515	Pathway support	Awaiting confirmation of ASDCF, finance to be agreed.		Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS	ICB Discharge Funding		£220,000	£250,000
232516	Pathway 2 Medical Support - Summerhill	Medical cover provision for patients in designated intermediate care homes. (Summerhill)	Other						Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£62,759	£63,198
232517	Medical input into stepdown facilities - Saltwells	Medical input into stepdown facilities provided by DGFT (Included in the block - previously Saltwells)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£88,969	£89,592
232518																		
232519	Pathway 2 Step Down Occupational Therapy	Pathway 2 Step down - Occupational Therapy Services based at Tiled House. (Provider - DGFT)	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution	Existing	£548,471	£552,310
232520	Pathway 2 Step Down Physiotherapy	Step Down Physiotherapy Services provided within Local Acute Community Trust	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care					Community Health		NHS			NHS	Minimum NHS Contribution	Existing	£211,224	£212,703
232521	Pathway 2 Step Down Physiotherapy	Step Down Physiotherapy Services provided by private provider	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£69,045	£69,528
232522	Support for discharge	Awaiting confirmation of ASDCF, finance to be agreed.	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			Private Sector	ICB Discharge Funding	Existing	£745,877	£1,801,802
232523	Pathway 2 beds	Block pathway 2 capacity Intermediate/Stepdown Care	Residential Placements	Short-term residential/nursing care for someone likely to require a					Community Health		NHS			Private Sector	Additional NHS Contribution	Existing	£960,823	£444,545

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Dudley

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	187.8	152.8	301.7	141.0	The figures have been generated using standard Excel functionality using standard forecasting. Due to the changes in the way numbers are counted it has been difficult to forecast more accurately and we will have to explore locally held data.	The avoidable admissions data has increased at DGFT but could be a result of coding. The base data used reflects COVID operating conditions and recent counting and coding changes at Dudley Group of Hospitals (Same Day Emergency Care has been included in SUS inpatient data flows since late September 2022	Yes
	Number of Admissions	704	573	1,131	-			
	Population	320,626	320,626	320,626	320,626			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	889	915	940	965			Yes

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

8.2 Falls

			2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value		1,790.1	1,874.0	2,108.8	Falls are a key priority for Dudley place. There has been significant amount of work to reduce both falls and falls conveyances through the clinical HUB.	The Clinical Hub, 2-hour response Admissions Avoidance Service has launched a focused falls Response provision. Initial findings has shown that 90% of people who used this service have had an ED attendance avoided. Data is being collated monthly. There is a local implementation plan for this project, with	Yes
	Count		1,215	1268	1427			Yes
	Population		66,258	66258	66258			Yes

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.1%	94.0%	93.1%	95.0%	Acute and Social Care have a robust long standing system in place to discharge patients to their normal place of residence with existing care provision i.e. Nursing, residential or package of care.	Continuation of integrated working of daily reviews of Delayed Transfers of Care (DTOC) to ensure timely discharge. This is a well-established and robust system and utilises the DISCO database with ICB, Acute hospital and Local Authority.	Yes
	Numerator	6,251	6,300	6,350	6,408			
	Denominator	6,713	6,700	6,821	6,746			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	90.8%	90.5%	90.7%	90.9%			
	Numerator	6,118	6,129	6,141	6,152			Yes
	Denominator	6,738	6,772	6,770	6,768			Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	789.0	700.0	954.7	798.2	Due to the implementation of a Placement Brokerage team to support with residential and nursing placements.	Using the support of the placement brokerage team this should enable workers to complete more assessments while the brokerage team are supporting with transfer of placements from pathway 3	Yes
	Numerator	518	470	641	540			Yes
	Denominator	65,656	67,141	67,141	67,649			

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

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.8%	83.0%	84.6%	86.0%	Set up of Support Discharge Team which will incorporate a reablement element and with the correct screening and intervention at the right point and support with 3 discharges per day.	Supported Discharge team and Discharge to Assess Group. Looking at readmissions and inappropriate discharges and working with the hospital to see why this is.	Yes
	Numerator	199	224	750	929			Yes
	Denominator	232	270	887	1,080			Yes