APPENDIX 1

# Better Care Fund 2023-24 Year End Reporting Template

**1. Guidance for Year-End**

## Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), working with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). An addendum to the Policy Framework and Planning Requirements has also been published, which provides some further detail on the
The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to

BCF reporting can be used by local areas, including ICBs, local authorities/HWBs and service providers, to further understand and progress the integration of health, social care and housing on their patch. BCF national partners will also use the information submitted in these reports to aid with a bigger-picture

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

**Note on entering information into this template**
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

**Note on viewing the sheets optimally**
To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that

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

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

## Checklist ( 2. Cover )

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word '
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will c

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

## 2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and spend from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority
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

## 3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned

## 4. Metrics

The latest BCF plans required areas to set stretching ambitions against the following metrics for 2023-24:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

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

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

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

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

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Westmorland and Cumbria (due to a change in footprint).

## 5. Income and Expenditure

The Better Care Fund 2023-24 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Additional Discharge Fund.

**Income section:**

- Please confirm the total HWB level actual BCF pooled income for 2023-24 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ADF via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2023-24 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2023-24 in the yellow boxes provided, **NOT** the
- Please provide any comments that may be useful for local context for the reported actual income in 2023-24.

## 6. Spend and activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to year-end.

**The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:**

| **Scheme Type** | **Units** |
|---|---|
| Assistive technologies and equipment | Number of beneficiaries |
| Home care and domiciliary care | Hours of care (unless short-term in which case packages) |
| Bed based intermediate care services | Number of placements |
| Home based intermediate care services | Packages |
| DFG related schemes | Number of adaptations funded/people supported |
| Residential Placements | Number of beds/placements |
| Workforce recruitment and retention | Whole Time Equivalents gained/retained |

Carers services | Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:
- **Actual expenditure to date in column K.** Enter the amount of spend to date on the scheme.
- **Outputs delivered to date in column N**. Enter the number of outputs delivered to date. For example, for a

## 7.1 C&D Hospital Discharge and 7.2 C&D Community

When submitting actual demand/activity data on short and intermediate care services, consideration should be given to the equivalent data for long-term care services for 2023-24 that have been submitted as part of the Market Sustainability and Improvement Fund (MSIF) Capacity Plans, as well as confirming that BCF planning and wider NHS planning are aligned locally. We strongly encourage co-ordination between local authorities and the relevant Integrated Care Boards to ensure the information provided across both returns is consistent.

These tabs are for reporting actual commisioned activity,  for the period April 2023 to March 2024. Once your Health and Wellbeing Board has been selected in the cover sheet, the planned demand data from April 2023 to October 2023 will be auto-populated into the sheet from 2023-25 BCF plans, and planned data from November 2023 to March 2024 will be auto-populated from 2024-25 plan updates.

In the 7.1 C&D Hospital Discharge tab, the first half of the template is for actual activity without including spot purchasing - buying individual packages of care on an ‘as and when’ basis. Please input the actual number of new clients received, per pathway, into capacity that had been block purchased. For further detail on the definition of spot purchasing, please see the 2024-25 Capacity and Demand Guidance document, which can be found on the Better Care Exchange here:
https://future.nhs.uk/bettercareexchange/view?objectID=202784293

The second half is for actual numbers of new clients received into spot-purchased capacity only. Collection of spot-purchased capacity was stood up for the 2023-24 plan update process, but some areas did not input any additional capacity in this area, so zeros will pre-populate here for them.

## 8. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2023-24 through a set of survey questions
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions.

**Part 1 - Delivery of the Better Care Fund**
There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:
- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2023-24
3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in

**Part 2 - Successes and Challenges**

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

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

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally. The 9 points of the SCIE logic model are listed at the bottom of tab 8 and at the link below.
SCIE - Integrated care Logic Model

HM Government

NHS England

## Better Care Fund 2023-24 Year End Reporting Template

**2. Cover**

**Version 2.0**

*Please Note:*

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

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

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

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

| | | | Checklist<br>Complete: |
|---|---|---|---|
| **Health and Wellbeing Board:** | Dudley | | Yes |
| **Completed by:** | Sarah Knight/ Joanne Vaughan | | Yes |
| **E-mail:** | sarah.knight3@nhs.net - Joanne.vaughan@dudley.gov.uk | | Yes |
| **Contact number:** | S Knight - 07780664425 | | Yes |
| **Has this report been signed off by (or on behalf of) the HWB at the time of submission?** | No | | Yes |
| **If no, please indicate when the report is expected to be signed off:** | Thu 13/06/2024 | << Please enter using the format, DD/MM/YYYY | Yes |

**When all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.**

| | **Complete:** |
|---|---|
| 2. Cover | Yes |
| 3. National Conditions | Yes |
| 4. Metrics | Yes |
| 5. I&E actual | Yes |
| 6. Spend and activity | Yes |
| 7.1 C&D Hospital Discharge | Yes |
| 7.2 C&D Community | Yes |
| 8. Year End Feedback | Yes |

<< Link to the Guidance sheet

^^ Link back to top

# Better Care Fund 2023-24 Year End Reporting Template

**3. National Conditions**

Selected Health and Wellbeing Board: Dudley

| | | | Checklist Complete: |
|---|---|---|---|
| Has the section 75 agreement for your BCF plan been finalised and signed off? | Yes | | Yes |
| If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off | | | Yes |
| **Confirmation of National Conditions** | | | |
| National Conditions | Confirmation | If the answer is "No" please provide an explanation as to why the condition was not met in the year: | |
| 1) Jointly agreed plan | Yes | | Yes |
| 2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer | Yes | | Yes |
| 3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time | Yes | | Yes |
| 4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services | Yes | | Yes |

# Better Care Fund 2023-24 Year End Reporting Template

**4. Metrics**

Selected Health and Wellbeing Board: Dudley

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

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

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

| Metric | Definition | For information - Your planned performance as reported in 2023-24 planning | | | | Assessment of progress against the metric plan for the reporting period | Challenges and any Support Needs | Achievements - including where BCF funding is supporting improvements. | **Checklist** Complete: |
|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | | | | |
| **Avoidable admissions** | Unplanned hospitalisation for chronic ambulatory care sensitive conditions<br>(NHS Outcome Framework indicator 2.3i) | 224.5 | 230.2 | 236.0 | 241.7 | Not on track to meet target | There is ongoing work to encourage and find appropriate referral criteria to ensure the ambulance service utilise the admission avoidance support rather than conveying inappropriate patients to hospital. A call before convey function has been introduced during winter 2023-24 for >75, however this did not have any impact, the age limit has now been reduced to >60 and awaiting first set of data to measure impact. The Local Authority (LA) has a team called the Urgent Care Avoidance Team to support with social care need and further work is required to ensure this is well used. Referrals from 111 to the Clinical Hub are poor and work is underway to understand and address this. Work between the LA and Clinical Hub can be strengthened further by understanding what work can be done together to support care at home.<br><br>The Emergency Department (ED) admit social admissions where an admission avoidance bed would be appropriate. This is due to the limited capacity of admission avoidance beds, and results in acute bed admissions. The Own Bed Instead (OBI) Service supports admission avoidance and discharge, however, this service is not always utilised fully in a way which supports admission avoidance. | The admission avoidance function through the Clinical Hub has received an increase in referrals, particularly from care homes and GPs The Hub also works with Telecare staff who make direct referrals and attend joint visits with the Hub clinicians. The Falls Response Service is working well and responding to falls at home, predominantly Care Homes, and keeping patients away from ED when appropriate.<br><br>Admission avoidance will also be supported through a newly commissioned mental health worker, being based within our high intensity user service.<br><br>Within the Local Authority we use our Urgent Care team to support with approx. 25 (average with our capacity) assessments and care packages weekly to patients in their own home who have experienced a crisis to avoid attendance to hospital. | Yes |
| **Discharge to normal place of residence** | Percentage of people who are discharged from acute hospital to their normal place of residence | 93.0% | 93.0% | 93.0% | 93.1% | Not on track to meet target | The complexity and acuity of patients going through our system is extremely high. The added demand of patients requiring admission to hospital means that people are being discharged maybe earlier than the ideal situation meaning that often people go into a care setting that is more dependent than required. The plan would be to then move these people to a less intensive setting, but often people choose to remain. The challenge is to consistently offer a home first service. Within the LA a Dudley Short Term Assessment and Reablement Service (STARS) has been implemented. STARS offer a pathway 1 package of care (POC) to support with discharges, along with a reablement plan to allow patients to achieve their desired outcomes at home and return to their level of independence allowing flow within the system.<br><br>Pathway 1 discharges are more coordinated and improved hospital flow, however the capacity of POC is limited.<br>Discharge staff do not always consider home first and consider the wrap around services available in the community. Discharge staff are not always aware of the plethora of resources available in the community.<br><br>Challenges are experienced to ensure TTOs and transport issues correct.<br><br>Own Bed Instead is not utilised enough to support hospital discharge.<br><br>Ongoing challenges are experienced with discharging of out of area patients back to their normal place of residence as this cohort of patients experience delays to discharge to their normal place of residence. | There is a more robust and coordinated pathway 1 offer in place.<br><br>This has meant that capacity in pathway 1 has been consistent rather than having to support community-based support as well.<br><br>Demand is greater than capacity. Data accuracy is challenging and development is underway to address this issue | Yes |
| **Falls** | Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | | | | 2,341.2 | On track to meet target | Although existing services are delivering the falls response service, no further investment has been made to account for additional activity.<br><br>The Local Authority support the emergency EDT team and Telecare to respond to people who may have experienced falls and will provide an emergency package of care via our teams who work 24/7.<br><br>There is however, a waiting list for both falls assessments and patients waiting to access the falls programme and rehabilitation.<br><br>When people present with a fall, the threshold for admission appears lower due to the risk of further falls, the front door element needs to be more robust. A challenge is not receiving the referrals early enough into the pathway. | Falls in Dudley has an integrated pathway and a dedicated Falls Coordinator. A Falls front of house screening service is in place and aligns patients to the appropriate part of the Falls Pathway.<br><br>The Clinical Hub and OBI Teams work together around falls to urgently attend patients, avoid a hospital admission, and arrange ongoing therapy as appropriate.<br><br>Outputs from a recent Discharge Improvement week, together with the findings from the Changeology Capacity and Demand Report, will drive change and improvements via a co-produced, collaborative plan. | Yes |
| **Residential Admissions** | Rate of permanent admissions to residential care per 100,000 population (65+) | | | | 798 | On track to meet target | The introduction of the improved discharge process has seen more people returning home into the community with the focus of promoting independence and reablement from a p1 and p2 perspective.<br><br>We have a robust way in which pathway 3 assessments are now managed, which has had a significant reduction of length of stay has enabled more people to be considered for alternatives than 24hour placements. The continued demand for pathway 3 beds from acute trusts is greater than capacity - often referring for a pathway 3 bed when home first has not been considered. | There is a new more robust pathway for referring to pathway 3, with training given to ward staff and discharge staff to ensure patients are given all opportunities to return home to promote the home first approach. We have additional social work capacity to ensure people are assessed in a timely manner as soon as their therapy input is completed. | Yes |
| **Reablement** | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | | | | 86.0% | Not on track to meet target | The redesigned Reablement and Discharge service has been up and running since November 2023. There has been a large recruitment phase which has allowed opportunity for increased capacity of the therapeutic input. This increased level of Reablement is beginning to show improvement month upon month of the number of people that are successfully remaining at home. We are confident that in the next 12months this target will be met. | Part of the multidisciplinary team is to work together to review 'real' patient data to support with improvement plans. | Yes |

## Better Care Fund 2023-24 Year End Reporting Template

**5. Income actual**

Selected Health and Wellbeing Board: Dudley

## Income

| | 2023-24 | |
|---|---|---|
| Disabled Facilities Grant | £7,006,531 | |
| Improved Better Care Fund | £16,627,704 | |
| NHS Minimum Fund | £28,424,150 | |
| **Minimum Sub Total** | | £52,058,386 |

| | Planned | | Actual | | | | Checklist Complete: |
|---|---|---|---|---|---|---|---|
| NHS Additional Funding | £1,424,655 | | Do you wish to change your additional actual NHS funding? | Yes | £1,463,873 | | Yes |
| LA Additional Funding | £20,584,393 | | Do you wish to change your additional actual LA funding? | No | | | Yes |
| **Additional Sub Total** | | £22,009,048 | | | | £22,048,266 | |

| | Planned 23-24 | Actual 23-24 |
|---|---|---|
| **Total BCF Pooled Fund** | £74,067,434 | £74,106,652 |

### Additional Discharge Fund

| | Planned | | Actual | | | | Checklist |
|---|---|---|---|---|---|---|---|
| LA Plan Spend | £2,331,178 | | Do you wish to change your additional actual LA funding? | No | | | Yes |
| ICB Plan Spend | £1,489,628 | | Do you wish to change your additional actual ICB funding? | No | | | Yes |
| **Additional Discharge Fund Total** | | £3,820,806 | | | | £3,820,806 | |

| | Planned 23-24 | Actual 23-24 |
|---|---|---|
| **BCF + Discharge Fund** | £77,888,240 | £77,927,458 |

| Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2023-24 | Additional NHS Contribution overspend was attributable to additional P2 Neuro-rehab beds due to increased demand. | Yes |
|---|---|---|

## Expenditure

| | 2023-24 |
|---|---|
| Plan | £77,325,917 |

| Do you wish to change your actual BCF expenditure? | Yes | Yes |
|---|---|---|

| Actual | £73,566,449 | Yes |
|---|---|---|

| Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2023-24 | LA underspend of -£2.893m to include addl DFG allocation of £562k. -£4.925m underspend on DFG (to be c/fwd to 24/25 - reduced c/fwd from 23/24 and commitments in place to utilise remaining c/fwd), -£347k net vacancy savings offset by +£2.378m pressure across community care packages. LA NHS minimum funding, iBCF and Discharge fund fully utilised in-year with overspends funded by LA budget. | Yes |
|---|---|---|

## Better Care Fund 2023-24 Year End Reporting Template

**6. Spend and activity**

Selected Health and Wellbeing Board: Dudley

| Checklist | | | | | | | Yes | | | Yes | | Yes | Yes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Scheme ID** | **Scheme Name** | **Scheme Type** | **Sub Types** | **Source of Funding** | **Planned Expenditure** | **Q3 Actual expenditure to date** | **Actual Expenditure to date** | **Planned outputs** | **Q3 Actual delivered outputs to date** | **Outputs delivered to date (estimate if unsure) (Number or NA)** | **Unit of Measure** | **Have there been any implementation issues?** | **If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.** |
| 1001 | Whole Population Prevention / Population Health Management | Carers Services | Other | Additional LA Contribution | £434,900 | £313,425 | £420,900 | 3,500 | 3,456 | 3456 | Beneficiaries | No | |
| 1002 | Whole Population Prevention / Population Health Management | Assistive Technologies and Equipment | Community based equipment | Minimum NHS Contribution | £520,300 | £390,225 | £520,300 | 6,618 | 5,492 | 6447 | Number of beneficiaries | No | |
| 1002 | Whole Population Prevention / Population Health Management | Assistive Technologies and Equipment | Community based equipment | Additional LA Contribution | £616,300 | £448,350 | £795,607 | 7,839 | 6,310 | 9858 | Number of beneficiaries | No | |
| 1003 | Whole Population Prevention / Population Health Management | DFG Related Schemes | Adaptations, including statutory DFG grants | DFG | £4,677,209 | £0 | £762,142 | 240 | - | 52 | Number of adaptations funded/people supported | No | |
| 1003 | Whole Population Prevention / Population Health Management | DFG Related Schemes | Discretionary use of DFG | DFG | £695,000 | £521,250 | £708,729 | 8,840 | 7,336 | 8781 | Number of adaptations funded/people supported | No | |
| 1003 | Whole Population Prevention / Population Health Management | DFG Related Schemes | Discretionary use of DFG | DFG | £500,000 | £0 | - | 50 | - | 0 | Number of adaptations funded/people supported | No | |
| 1003 | Whole Population Prevention / Population Health Management | DFG Related Schemes | Discretionary use of DFG | DFG | £150,000 | £112,500 | £150,000 | 35 | 17 | 19 | Number of adaptations funded/people supported | No | |
| 1003 | Whole Population Prevention / Population Health Management | DFG Related Schemes | Discretionary use of DFG | DFG | £375,000 | £245,602 | £427,551 | 1,850 | 1,668 | 2313 | Number of adaptations funded/people supported | No | |
| 1003 | Whole Population Prevention / Population Health Management | DFG Related Schemes | Handyperson services | DFG | £47,000 | £0 | £33,271 | 612 | - | 635 | Number of adaptations funded/people supported | No | |
| 1003 | Whole Population Prevention / Population Health Management | DFG Related Schemes | Adaptations, including statutory DFG grants | Additional LA Contribution | £5,024,000 | £4,936,897 | £5,024,000 | 260 | 275 | 345 | Number of adaptations funded/people supported | No | |
| 1005 | Whole Population Prevention / Population Health Management | Carers Services | Other | Minimum NHS Contribution | £219,400 | £184,650 | £239,429 | 3,500 | 3,456 | 3456 | Beneficiaries | No | |
| 2001 | Urgent Care Needs – Integrated Access & Rapid Response | Home-based intermediate care services | Reablement at home (accepting step up and step | Minimum NHS Contribution | £200,400 | £150,300 | £200,400 | 265 | 310 | 426 | Packages | No | |
| 2001 | Urgent Care Needs – Integrated Access & Rapid Response | Home-based intermediate care services | Reablement at home (accepting step up and step | Additional LA Contribution | £34,200 | £27,900 | £32,083 | 45 | 58 | 68 | Packages | No | |
| 3001 | Ongoing Care Needs - Enhanced Primary & Community Care | Home Care or Domiciliary Care | Domiciliary care packages | Minimum NHS Contribution | £7,083,923 | £5,312,942 | £7,083,923 | 479,629 | 392,968 | 512111 | Hours of care (Unless short-term in which case it is packages) | No | |
| 3001 | Ongoing Care Needs - Enhanced Primary & Community Care | Home Care or Domiciliary Care | Domiciliary care packages | iBCF | £6,426,513 | £4,819,885 | £6,426,513 | 435,118 | 356,500 | 464585 | Hours of care (Unless short-term in which case it is packages) | No | |
| 3001 | Ongoing Care Needs - Enhanced Primary & Community Care | Home Care or Domiciliary Care | Domiciliary care packages | Additional LA Contribution | £1,638,664 | £2,845,783 | £2,675,960 | 110,948 | 210,486 | 193450 | Hours of care (Unless short-term in which case it is packages) | No | |
| 3003 | Ongoing Care Needs - Enhanced Primary & Community Care | Carers Services | Respite services | Minimum NHS Contribution | £89,100 | £39,450 | £56,471 | 150 | 135 | 200 | Beneficiaries | No | |
| 4001 | Highest Care Needs – coordinated community-based and inpatient care | Home-based intermediate care services | Reablement at home (accepting step up and step | Minimum NHS Contribution | £724,400 | £543,300 | £724,400 | 2,188 | 1,639 | 2124 | Packages | No | |
| 4001 | Highest Care Needs – coordinated community-based and inpatient care | Home-based intermediate care services | Reablement at home (accepting step up and step | Additional LA Contribution | £790,300 | £585,525 | £753,375 | 2,188 | 1,639 | 2124 | Packages | No | |
| 4003 | Highest Care Needs – coordinated community-based and inpatient care | Bed based intermediate Care Services (Reablement, rehabilitation, wider short- | Bed-based intermediate care with reablement | Minimum NHS Contribution | £2,983,600 | £2,342,850 | £3,124,816 | 306 | 203 | 283 | Number of placements | No | |
| 4004 | Highest Care Needs – coordinated community-based and inpatient care | Home-based intermediate care services | Reablement at home (accepting step up and step | Minimum NHS Contribution | £2,235,600 | £1,676,700 | £2,235,600 | 1,687 | 953 | 1437 | Packages | No | |
| 4006 | Highest Care Needs – coordinated community-based and inpatient care | Home Care or Domiciliary Care | Domiciliary care packages | Minimum NHS Contribution | £246,100 | £184,575 | £246,100 | 22,076 | 16,557 | 22076 | Hours of care (Unless short-term in which case it is packages) | No | |
| 4006 | Highest Care Needs – coordinated community-based and inpatient care | Home Care or Domiciliary Care | Domiciliary care packages | Additional LA Contribution | £1,610,789 | £1,931,100 | £2,213,303 | 144,490 | 173,222 | 198536 | Hours of care (Unless short-term in which case it is packages) | No | |
| 4007 | Highest Care Needs – coordinated community-based and inpatient care | Bed based intermediate Care Services (Reablement, rehabilitation, wider short- | Other | Minimum NHS Contribution | £204,300 | £153,225 | £204,300 | 48 | 23 | 30 | Number of placements | No | |
| 4007 | Highest Care Needs – coordinated community-based and inpatient care | Bed based intermediate Care Services (Reablement, rehabilitation, wider short- | Other | iBCF | £488,901 | £366,676 | £488,901 | 115 | 77 | 103 | Number of placements | No | |
| 4010 | Highest Care Needs – coordinated community-based and inpatient care | Home-based intermediate care services | Other | iBCF | £998,700 | £749,025 | £998,700 | 2,188 | 1,639 | 2124 | Packages | No | |
| 4013 | Highest Care Needs – coordinated community-based and inpatient care | Home Care or Domiciliary Care | Domiciliary care packages | iBCF | £1,561,621 | £1,171,216 | £1,561,621 | 98,976 | 74,232 | 98976 | Hours of care (Unless short-term in which case it is packages) | No | |
| 5001 | Discharge to Assess | Home Care or Domiciliary Care | Domiciliary care packages | Local Authority Discharge Funding | £732,164 | £786,559 | £824,084 | 37,128 | 39,886 | 59575 | Hours of care (Unless short-term in which case it is packages) | No | |
| 5001 | Discharge to Assess | Home-based intermediate care services | Reablement at home (accepting step up and step | Local Authority Discharge Funding | £1,000,000 | £1,208,323 | £1,208,323 | 501 | 687 | 687 | Packages | No | |
| 5002 | Additional Pathway 3 beds | Residential Placements | Short-term residential/nursing care for someone | Local Authority Discharge Funding | £262,718 | £0 | - | | - | 0 | Number of beds/placements | No | |
| 5003 | Additional equipment | Assistive Technologies and Equipment | Community based equipment | Local Authority Discharge Funding | £200,000 | £87,445 | £167,179 | 2,544 | 1,231 | 2071 | Number of beneficiaries | No | |
| 232501 | Tissue Viability Service | Assistive Technologies and Equipment | Community based equipment | Minimum NHS Contribution | £1,287,006 | £971,904 | £1,295,873 | 1,550 | 1,624 | 2929 | Number of beneficiaries | No | |
| 232506 | Pathway 2 Beds | Residential Placements | Short-term residential/nursing care for someone | Minimum NHS Contribution | £2,063,159 | £2,095,768 | £2,680,615 | | 53 | 57 | Number of beds/placements | No | |
| 232507 | Additional Pathway 2 Beds capacity (ASCDF - Line 1 and 2) | Residential Placements | Short-term residential/nursing care for someone | ICB Discharge Funding | £280,000 | £476,388 | £688,594 | | 28 | 31 | Number of beds/placements | No | |
| 232508 | Pathway 3 Beds | Bed based intermediate Care Services (Reablement, rehabilitation, wider short- | Bed-based intermediate care with reablement | Minimum NHS Contribution | £1,093,476 | £833,369 | £973,159 | 37 | 36 | 54 | Number of placements | No | |
| 232509 | Pathway 2 Neuro Rehab Beds | Bed based intermediate Care Services (Reablement, rehabilitation, wider short- | Bed-based intermediate care with rehabilitation | Minimum NHS Contribution | £550,000 | £956,039 | £1,240,308 | 29 | 31 | 38 | Number of placements | No | |
| 232510 | Pathway 2 Neuro Rehab Beds ASCDF | Bed based intermediate Care Services (Reablement, rehabilitation, wider short- | Bed-based intermediate care with rehabilitation | ICB Discharge Funding | £100,000 | £0 | £0 | 2 | - | 0 | Number of placements | No | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

## Better Care Fund 2023-24 Capacity & Demand EOY Report

**7.1. Capacity & Demand**

Selected Health and Wellbeing Board: Dudley

### Estimated demand - Hospital Discharge

| | | Prepopulated from plan: | | | | | | | Q2 Refreshed planned demand | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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** |
| Reablement & Rehabilitation at home (pathway 1) | Planned demand. Number of referrals. | 168 | 175 | 140 | 137 | 149 | 148 | 175 | 171 | 159 | 216 | 150 | 176 |
| Short term domiciliary care (pathway 1) | Planned demand. Number of referrals. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Planned demand. Number of referrals. | 65 | 65 | 65 | 63 | 55 | 56 | 78 | 55 | 63 | 68 | 58 | 57 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Planned demand. Number of referrals. | 55 | 72 | 66 | 61 | 63 | 63 | 77 | 51 | 50 | 46 | 37 | 39 |

### Actual activity - Hospital Discharge

**Actual activity (not spot purchase):**

| **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** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reablement & Rehabilitation at home (pathway 1) | Monthly activity. Number of new clients. | 116 | 114 | 144 | 140 | 119 | 142 | 147 | 134 | 190 | 169 | 176 | 176 |
| Short term domiciliary care (pathway 1) | Monthly activity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Monthly activity. Number of new clients. | 0 | 0 | 55 | 61 | 48 | 52 | 55 | 58 | 52 | 61 | 49 | 51 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Monthly activity. Number of new clients. | 59 | 51 | 58 | 48 | 50 | 47 | 65 | 58 | 59 | 61 | 52 | 49 |

### Actual activity - Hospital Discharge

**Actual activity in spot purchasing:**

| **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** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reablement & Rehabilitation at home (pathway 1) | Monthly activity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short term domiciliary care (pathway 1) | Monthly activity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Monthly activity. Number of new clients. | 0 | 2 | 1 | 10 | 3 | 4 | 4 | 1 | 2 | 3 | 1 | 7 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Monthly activity. Number of new clients. | 23 | 36 | 30 | 20 | 13 | 15 | 34 | 25 | 37 | 37 | 26 | 18 |

**Checklist**

Complete:

Yes
Yes
Yes
Yes

Yes
Yes
Yes
Yes

## Better Care Fund 2023-24 Capacity & Demand Refresh

**7.2 Capacity & Demand**

Selected Health and Wellbeing Board: Dudley

| Demand - Community | | Prepopulated from plan: | | | | | | | Q2 refreshed expected demand | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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)** | Planned demand. Number of referrals. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Urgent Community Response** | Planned demand. Number of referrals. | 97 | 80 | 84 | 83 | 55 | 84 | 72 | 87 | 102 | 117 | 90 | 117 |
| **Reablement & Rehabilitation at home** | Planned demand. Number of referrals. | 168 | 175 | 140 | 137 | 149 | 148 | 175 | 171 | 159 | 216 | 150 | 176 |
| **Reablement & Rehabilitation in a bedded setting** | Planned demand. Number of referrals. | 6 | 4 | 3 | 3 | 4 | 4 | 4 | 6 | 6 | 6 | 6 | 6 |
| **Other short-term social care** | Planned demand. Number of referrals. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Actual activity - Community | | Actual activity: | | | | | | | | | | | | Checklist Complete: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 activity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| **Urgent Community Response** | Monthly activity. Number of new clients. | 92 | 89 | 91 | 71 | 58 | 72 | 93 | 101 | 78 | 122 | 76 | 52 | Yes |
| **Reablement & Rehabilitation at home** | Monthly activity. Number of new clients. | 116 | 114 | 144 | 140 | 119 | 142 | 147 | 134 | 190 | 169 | 176 | 176 | Yes |
| **Reablement & Rehabilitation in a bedded setting** | Monthly activity. Number of new clients. | 0 | 2 | 1 | 10 | 3 | 4 | 4 | 1 | 2 | 3 | 1 | 7 | Yes |
| **Other short-term social care** | Monthly activity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |

## Better Care Fund 2023-24 Year End Reporting Template

**8. Year-End Feedback**

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

Selected Health and Wellbeing Board: Dudley

**Part 1: Delivery of the Better Care Fund**

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

| Statement: | Response: | Comments: Please detail any further supporting information for each response | Checklist Complete: |
|---|---|---|---|
| 1. The overall delivery of the BCF has improved joint working between health and social care in our locality | Strongly Agree | Dudley Place has implemented a cross organisational PMO Team to support and oversee the BCF programme of work. This function has not been funded from the BCF, it has been developed using existing resources from across health and social care. Monitoring and effectiveness of our better care information will be more robust due to the information and governance framework. Feedback from all partners has been positive, there is a keen desire to continue to strengthen collaborative working.<br>An Integrated approach has been adopted between health and social care to reduce spot purchasing for Pathway 3 by flexing capacity within a Pathway 2 rehabilitation unit, which has improved patient experience and improved flow from the acute setting.<br>Own Bed Instead (OBI) have good relationships with the Local Authority, there is integration in place for the delivery of patient care.<br>The Urgent Care Response Team (UCRT) are working jointly with the Local Authority with deteriorating patients and the falls pathway.<br>Telecare can refer patients into the UCRT when in crisis to prevent patients attending ED | Yes |
| 2. Our BCF schemes were implemented as planned in 2023-24 | Strongly Agree | Yes, some slight delays with recruitment for the new schemes, due to be in post by June 2024, all implemented as per plan. | Yes |
| 3. The delivery of our BCF plan in 2023-24 had a positive impact on the integration of health and social care in our locality | Strongly Agree | Yes, we are also now exploring further opportunities for joint commissioning and feel that are receiving a better experience and timely discharges from hospital by looking at greater digital connections between systems.<br>There is a understanding between NHS community staff and local authority that we work more collaboratively to meet the needs of the patient | Yes |

**Part 2: Successes and Challenges**

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

Please provide a brief description alongside.

| 4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24 | SCIE Logic Model Enablers, Response category: | Response - Please detail your greatest successes | Checklist Complete: |
|---|---|---|---|
| Success 1 | 2. Strong, system-wide governance and systems leadership | Management of the BCF plan: Over the last 12 months we have produced a stronger governance and monitoring framework for Better Care Planning across Dudley. We have developed and implemented a cross organisational PMO Team to support and oversee the BCF programme of work for Dudley Place. This function has not been funded from the BCF, this has been developed using existing resources from across health and social care.<br>A BCF framework will be implemented which will provide clear and robust assurance. Continuous work is underway to improve the flow and quality of data to support development of the Dudley BCF Metrics pack, as well as to aid decision making for new and existing schemes. The PMO function will provide greater scrutiny to all of the BCF lines and the team will provide reports into the executive committees. | Yes |
| Success 2 | Other | Implementation of the Short term reablement team (STARS) has enabled people to have reablement at the point of need, long term assessment requirements are also assessed, all supporting improved hospital flow. The investment has meant that the team is more resilient and sustainable and hospital discharge pathways are more robust. The team has recruited more therapy staff and has a stronger management structure. There will be further development over the next 12 months. | Yes |

| 5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2023-24 | SCIE Logic Model Enablers, Response category: | Response - Please detail your greatest challenges | Checklist Complete: |
|---|---|---|---|
| Challenge 1 | 6. Good quality and sustainable provider market that can meet demand | OBI recruitment of therapy staff has been the greatest challenge in the past 12 months. The team have tried to review ways of working and skill mixing across other services and teams during winter pressures. This has meant that vacancies have been in place across the own bed instead service, we will continue to be creative in ensuring that these skill sets are available to the team but we are hopeful that over the next 12 months recruitment will become more stable. | Yes |
| Challenge 2 | 9. Joint commissioning of health and social care | Pathway 2 length of stay (LOS) remains greater than the national average. One issue is lack of a shared data platform with which to share information across health and social care with lack of shared care records. One of the greatest challenges for reducing the length of stay in pathway 2 is the ability to get timely social work assessments and then timely commencement of packages of care. We have tried to mitigate by funding additional social work capacity specifically for bed based services, this works well for simple type discharges, but when the persons situation is more complex, involving for example complex housing issues, then more specialist social work resource is required. This then delays discharge dates and extends length of stay. | Yes |

**Footnotes:**

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

Other

APPENDIX 2

# BCF Planning Template 2024-25

**1. Guidance**

## Overview

**Note on entering information into this template**

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

| Data needs inputting in the cell |
| --- |
| Pre-populated cells |

## 2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

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 in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

6. Please ensure that all boxes on the checklist are green before submission.

7. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

## 4. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

**4.2 Hospital Discharge**

A new text field has been added this year, asking  for a description of the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation. Please answer this briefly, in a couple of sentences.

The capacity section of this template remains largely the same as in previous years, asking for estimates of available capacity for each month of the year for each pathway. An additional ask has now also been included, for the estimated average time between referral and commencement of service. Further information about this is available in the capacity and demand guidance and q&a documents.

The demand section of this sheet is unchanged from last year, requesting expected discharges per pathway for each month, broken down by referral source.

To the right of the summary table, there is another new requirement for areas to include estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways. Please estimate this as an average across the whole year.

**4.3 Community**

Please enter estimated capacity and demand per month for each service type.

The community sheet also requires areas to enter estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

## 5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2024-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations, DFG allocations and allocations of ASC Discharge Fund grant to local authorities for 2024-25. The iBCF grant in 2024-25 remains at the same value nationally as in 2023-24.

2. The sheet will be largely auto-populated from either 2023-25 plans or confirmed allocations. You will be able to update the value of the following income types locally:

- ICB element of Additional Discharge Funding
- Additional Contributions (LA and ICB)

If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

3. The sheet will pre populate the amount from the ICB allocation of Additional Discharge Funding that was entered in your original BCF plan.  Areas will need to confirm and enter the final agreed amount  that will be allocated to the HWB's BCF pool in 2024-25. As set out in the Addendum to the Policy Framework and Planning Requirements; the amount of funding allocated locally to HWBs should be agreed between the ICB and councils. These will be checked against a separate ICB return to ensure they reconcile.

4. The additional contributions from ICBs and councils that were entered in original plans will pre-populate.  Please confirm the contributions for 2024-25.  If there is a change to these figures agreed in the final plan for 2024-25, please select 'Yes' in answer to the Question 'Do you wish to update your Additional (LA/ICB) Contributions for 2024-25?'. You will then be able to enter the revised amount. These new figures will appear as funding sources in sheet 6a when you are reviewing planned expenditure.

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

6. If you are pooling any funding carried over from 2023-24 (i.e. underspends from BCF mandatory contributions) you should show these as additional contributions, but on a separate line to any other additional contributions.  Use the comments field at the bottom of the sheet to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

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

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

## 6. Expenditure

This sheet has been auto-populated with spending plans for 2024-25 from your original 2023-25 BCF plans. You should update any 2024-25 schemes that have changed from the original plan. The default expectation is that plans agreed in the original plan will be taken forward, but where changes to schemes have been made (or where a lower level of discharge fund allocation was assumed in your original plan), the amount of expenditure and expected outputs can be amended. There is also space to add new schemes, where applicable.

If you need to make changes to a scheme, you should select yes from the drop down in column X. When 'yes' is selected in this column, the 'updated outputs for 2024-25' and 'updated spend for 2024-25' cells turn yellow and become editable for this scheme. If you would like to remove a scheme type please select yes in column X and enter zeros in the editable columns.  The columns with yellow headings will become editable once yes is selected in column X - if you wish to make further changes to a scheme, please enter zeros into the editable boxes and use the process outlined below to re-enter the scheme.

If you need to add any new schemes, you can click the link at the top of the sheet that reads 'to add new schemes' to travel quickly to this section of the table.

For new schemes, as with 2023-25 plans, the table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet, please enter the following information:

**1. Scheme ID:**

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

**2. Scheme Name:**

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

**3. Brief Description of Scheme**

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

**4. Scheme Type and Sub Type:**

- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.

- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn ""yellow"". Please select the Sub Type from the dropdown list that best describes the scheme being planned.

- Please note that the dropdown list has a scroll bar to scroll through the list and all the options may not appear in one view.

- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.

- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

**5. Expected outputs**

- You will need to set out the expected number of outputs you expect to be delivered in 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.

- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.

- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

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

- A change has been made to the standard units for residential placements. The units will now read as 'Beds' only, rather than 'Beds/placements'

**6. Area of Spend:**

- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.

- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.

**7. Commissioner:**

- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.

- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.

- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

**8. Provider:**

- Please select the type of provider commissioned to provide the scheme from the drop-down list.

- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

# Better Care Fund 2024-25 Update Template

## 2. Cover

**Version 1.3.0**

*Please Note:*

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

| | |
|---|---|
| **Health and Wellbeing Board:** | Dudley |
| **Completed by:** | Sarah Knight/ Joanne Vaughan |
| **E-mail:** | sarah.knight3@nhs.net - Joanne.vaughan@dudley.gov.uk |
| **Contact number:** | S Knight - 07780664425 |
| **Has this report been signed off by (or on behalf of) the HWB at the time of submission?** | No |
| **If no please indicate when the HWB is expected to sign off the plan:** | Thu 13/06/2024 |

<< Please enter using the format, DD/MM/YYYY

| | Role: | Professional Title (e.g. Dr, Cllr, Prof) | First-name: | Surname: | E-mail: |
|---|---|---|---|---|---|
| ***Area Assurance Contact Details:** | Health and Wellbeing Board Chair | Cllr | 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 |
| | | | | | |
| | | | | | |

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 |
| 4.2 C&D Hospital Discharge | Yes |
| 4.3 C&D Community | Yes |
| 5. Income | Yes |
| 6a. Expenditure | No |
| 7. Narrative updates | Yes |
| 8. Metrics | Yes |
| 9. Planning Requirements | Yes |

<< Link to the Guidance sheet

^^ Link back to top

# Better Care Fund 2024-25 Update Template

**3. Summary**

Selected Health and Wellbeing Board: Dudley

## Income & Expenditure

Income >>

| Funding Sources | Income | Expenditure | Difference |
|---|---|---|---|
| DFG | £7,029,024 | £7,029,024 | £0 |
| Minimum NHS Contribution | £30,032,957 | £30,032,957 | £0 |
| iBCF | £16,627,704 | £16,627,704 | £0 |
| Additional LA Contribution | £24,079,855 | £24,079,855 | £0 |
| Additional ICB Contribution | £2,489,441 | £2,489,441 | £0 |
| Local Authority Discharge Funding | £3,885,297 | £3,885,297 | £0 |
| ICB Discharge Funding | £2,780,140 | £2,780,140 | £0 |
| **Total** | **£86,924,419** | **£86,924,418** | **£1** |

Expenditure >>

**NHS Commissioned Out of Hospital spend from the minimum ICB allocation**

| | 2024-25 |
|---|---|
| Minimum required spend | £8,534,515 |
| Planned spend | £11,141,241 |

**Adult Social Care services spend from the minimum ICB allocations**

| | 2024-25 |
|---|---|
| Minimum required spend | £18,891,716 |
| Planned spend | £18,891,716 |

Metrics >>

### Avoidable admissions

| | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan |
|---|---|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population) | 313.8 | 324.5 | 335.5 | 346.1 |

### Falls

| | | 2023-24 estimated | 2024-25 Plan |
|---|---|---|---|
| Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | Indicator value | 1,656.7 | 1,426.2 |
| | Count | 1129 | 971.9428683 |
| | Population | 66258 | 66258 |

### Discharge to normal place of residence

| | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan |
|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | 93.6% | 94.3% | 93.2% | 93.1% |

### Residential Admissions

| | | 2022-23 Actual | 2024-25 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 | 540 | 353 |

Planning Requirements >>

| Theme | Code | Response |
|---|---|---|

| | | |
|---|---|---|
| NC1: Jointly agreed plan | PR1 | Yes |
| | PR2 | 0 |
| | PR3 | Yes |
| NC2: Social Care Maintenance | PR4 | Yes |
| NC3: NHS commissioned Out of Hospital Services | PR5 | 0 |
| 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 2024-25 Update Template

**4. Capacity & Demand**

Selected Health and Wellbeing Board: Dudley

Checklist

Hospital Discharge

### Capacity - Demand (positive is Surplus)

Capacity surplus. Not including spot purchasing

| Capacity - Demand (positive is Surplus) | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reablement & Rehabilitation at home (pathway 1) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short term domiciliary care (pathway 1) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | 5 | 3 | 4 | -5 | 2 | 1 | -4 | 4 | 3 | 2 | 4 | -12 |
| Other short term bedded care (pathway 2) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Capacity surplus (including spot puchasing)

| Capacity - Demand (positive is Surplus) | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reablement & Rehabilitation at home (pathway 1) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short term domiciliary care (pathway 1) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | 5 | 5 | 5 | 5 | 5 | 5 | 0 | 5 | 5 | 5 | 5 | -5 |
| Other short term bedded care (pathway 2) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Average LoS/Contact Hours per episode of care

| Pathway | Full Year | Units | Complete: |
|---|---|---|---|
| Reablement & Rehabilitation at home (pathway 1) | 0 | Contact Hours per package | Yes |
| Short term domiciliary care (pathway 1) | 0 | Contact Hours per package | Yes |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | 45.5 | Average LoS (days) | Yes |
| Other short term bedded care (pathway 2) | 0 | Average LoS (days) | Yes |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | 0 | Average LoS (days) | Yes |

**Please briefly describe the support you are providing to people for less complex discharges that do not require formal reablement or rehabilitation – e.g. social support from the voluntary sector, blitz cleans. You should also include an estimate of the number of people who will receive this type of service during the year.**

Telecare:
Telecare will support hospital discharges by prioritising all installs, where possible, to the same day the referral is made . We support the hospital, to be able to safely discharge a patient to their home knowing that should they need support or have a fall, then Telecare will pick up the alert and initiate the appropriate response/action. Telecare will work with the hospital to meet at the patient/nok at the home to ensure everything that is required is fitted timely, following up, post discharge to ensure nothing further is required.

Occupational Therapy:
Occupational therapy in Access and Prevention has a key role in preventing hospital admission and keeping people safe an independent in their own homes.
The therapy team provides proportionate strengths based assessments. The core business of Access and Prevention OT is risk management and environmental and functional and transfer assessment at home.
Outcomes of assessment can include provision of Equipment, minor and /or major adaptation or advice and coaching and suggesting alternative techniques to complete tasks.
In the financial year 23-24, 3098 Assessments were completed by the Access and Prevention team.
In the same year the Access and Prevention duty team resolved between 20-27 percent of contacts by provision of equipment at duty usually with a timely follow up by a driver assessor or team assistant.
Also in the same year, through effective signposting the team supported 6-10% of contacts by connecting them to appropriate community assets.

Enhanced Handy Person Scheme:
The service supports people being discharged from hospital following an in-patient stay and provides a low level first contact and referral service as well as low-level practical tasks. This is predominately delivered to older people but does not exclude anyone under the age of 65 yrs.+ where they have no support from family/friends. It is a tenure neutral service and helps to improve or maintain wellbeing and quality of life, reduces risk of further illness/injury. The service is offered to people who identify with various vulnerabilities. The "offer" focuses on providing a "same-day" / 24 hour response (a) practical issues that can hold up a safe discharge home i.e. bed moving (one floor to another/same level,) lost keys/lock issues, small electrical / plumbing issues, setting up heating, house clearing (minimalize clutter to accommodate hospital bed,) safety of property; (b) provide advice and support relating to home safety and security and (c) introduce the person to other service who will help improve their independence, health and wellbeing. Upwards of 75 referrals anticipated which is reliant upon discharge teams making referrals to the service.

Living Well Feeling Safe:
This service provides a key safe installation service for people who are being discharged from hospital that allows their chosen provider of care to access their property if they are not able to "open the front door" to them, so they can receive ongoing support via a package of care that assists with personal care and/or administration of medication to enable them to remain independent within their local community/own home. It is anticipated that 150+ referrals will be acted upon during the year

Falls Service:
The falls pathway supports patients discharged from hospital following an inpatient stay or presentation to the Emergency Department. This support is triggered by a referral into the service from the hospital. Patients receive a multifactorial assessment to identify modifiable falls risks and seeks to maximise the reduction of risk through information and advice, demonstration of strength and balance exercise, home modification and rehabilitation by Physiotherapists and Occupational Therapists. The falls pathway discharged 119 patients who were referred into the service from hospital in the 2023/24 financial year and it is likely to be a similar number during this next twelve months.

Yes

### Capacity - Hospital Discharge

Refreshed planned capacity (not including spot purchased capacity

| Service Area | Metric | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reablement & Rehabilitation at home (pathway 1) | Monthly capacity. Number of new packages commenced. | 188 | 216 | 171 | 211 | 159 | 175 | 235 | 184 | 193 | 271 | 194 | 185 |
| Reablement & Rehabilitation at home (pathway 1) | Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased) | 4 | 3 | 3 | 2 | 3 | 3 | 4 | 4 | 4 | 4 | 3 | 4 |
| Short term domiciliary care (pathway 1) | Monthly capacity. Number of new packages commenced. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short term domiciliary care (pathway 1) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Monthly capacity. Number of new packages commenced. | 56 | 52 | 55 | 61 | 48 | 52 | 55 | 58 | 52 | 61 | 49 | 51 |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 2 | 1 |
| Other short term bedded care (pathway 2) | Monthly capacity. Number of new packages commenced. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other short term bedded care (pathway 2) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Monthly capacity. Number of new packages commenced. | 45 | 61 | 56 | 32 | 30 | 32 | 20 | 40 | 61 | 58 | 36 | 13 |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 6 | 5 | 4 | 5 | 4 | 4 | 4 | 5 | 5 | 6 | 6 | 6 |

Capacity that you expect to secure through spot purchasing

| Service Area | Metric | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Complete: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reablement & Rehabilitation at home (pathway 1) | Monthly capacity. Number of new packages commenced. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Reablement & Rehabilitation at home (pathway 1) | Estimated average time from referral to commencement of service (days). All packages (planned and spot purchased) | | | | | | | | | | | | | Yes |
| Short term domiciliary care (pathway 1) | Monthly capacity. Number of new packages commenced. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Short term domiciliary care (pathway 1) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | | | | | | | | | | | | | Yes |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Monthly capacity. Number of new packages commenced. | 0 | 2 | 1 | 10 | 3 | 4 | 4 | 1 | 2 | 3 | 1 | 7 | Yes |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | | | | | | | | | | | | | Yes |
| Other short term bedded care (pathway 2) | Monthly capacity. Number of new packages commenced. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Other short term bedded care (pathway 2) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | | | | | | | | | | | | | Yes |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Monthly capacity. Number of new packages commenced. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | | | | | | | | | | | | | Yes |

### Demand - Hospital Discharge

Please enter refreshed expected no. of referrals:

| Pathway | Trust Referral Source | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Complete: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total Expected Discharges:** | Total Discharges | **188** | **216** | **171** | **211** | **159** | **175** | **235** | **184** | **193** | **271** | **194** | **185** | Yes |
| Reablement & Rehabilitation at home (pathway 1) | Total | **188** | **216** | **171** | **211** | **159** | **175** | **235** | **184** | **193** | **271** | **194** | **185** | Yes |
| | DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | THE DUDLEY GROUP NHS FOUNDATION TRUST | 188 | 216 | 171 | 211 | 159 | 175 | 235 | 184 | 193 | 271 | 194 | 185 | Yes |
| | OTHER | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
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| **Short term domiciliary care (pathway 1)** | Total | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | Yes |
| | DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | THE DUDLEY GROUP NHS FOUNDATION TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | OTHER | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
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| **Reablement & Rehabilitation in a bedded setting (pathway 2)** | Total | **51** | **49** | **51** | **66** | **46** | **51** | **59** | **54** | **49** | **59** | **45** | **63** | Yes |
| | DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | THE DUDLEY GROUP NHS FOUNDATION TRUST | 51 | 49 | 51 | 66 | 46 | 51 | 59 | 54 | 49 | 59 | 45 | 63 | Yes |
| | OTHER | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
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| **Other short term bedded care (pathway 2)** | Total | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | Yes |
| | DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | THE DUDLEY GROUP NHS FOUNDATION TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | OTHER | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
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| **Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)** | Total | **45** | **61** | **56** | **32** | **30** | **32** | **20** | **40** | **61** | **58** | **36** | **13** | Yes |
| | DUDLEY INTEGRATED HEALTH AND CARE NHS TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | THE DUDLEY GROUP NHS FOUNDATION TRUST | 45 | 61 | 56 | 32 | 30 | 32 | 20 | 40 | 61 | 58 | 36 | 13 | Yes |
| | OTHER | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
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# Better Care Fund 2024-25 Update Template

**4. Capacity & Demand**

Selected Health and Wellbeing Board: Dudley

**Community**

Refreshed capacity surplus:

| Capacity - Demand (positive is Surplus) | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Average LoS/Contact Hours: Full Year | Units | Checklist Complete: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Contact Hours | Yes |
| Urgent Community Response | -99 | -99 | -99 | -103 | -103 | -103 | -103 | -103 | -186 | -186 | -137 | -137 | 9596.75 | Contact Hours | Yes |
| Reablement & Rehabilitation at home | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34757.25 | Contact Hours | Yes |
| Reablement & Rehabilitation in a bedded setting | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 45.5 | Average LoS | Yes |
| Other short-term social care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Contact Hours | Yes |

## Capacity - Community

Please enter refreshed expected capacity:

| Service Area | Metric | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Checklist |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | Monthly capacity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Urgent Community Response | Monthly capacity. Number of new clients. | 551 | 551 | 551 | 579 | 579 | 579 | 579 | 579 | 763 | 763 | 639 | 639 | Yes |
| Reablement & Rehabilitation at home | Monthly capacity. Number of new clients. | 188 | 216 | 171 | 211 | 159 | 175 | 235 | 184 | 193 | 271 | 194 | 185 | Yes |
| Reablement & Rehabilitation in a bedded setting | Monthly capacity. Number of new clients. | 51 | 47 | 50 | 56 | 43 | 47 | 55 | 53 | 47 | 56 | 44 | 56 | Yes |
| Other short-term social care | Monthly capacity. Number of new clients. | 5 | 11 | 12 | 12 | 11 | 8 | 9 | 7 | 9 | 12 | 11 | 11 | Yes |

## Demand - Community

Please enter refreshed expected no. of referrals:

| Service Type | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Checklist |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Urgent Community Response | 650 | 650 | 650 | 682 | 682 | 682 | 682 | 682 | 949 | 949 | 776 | 776 | Yes |
| Reablement & Rehabilitation at home | 188 | 216 | 171 | 211 | 159 | 175 | 235 | 184 | 193 | 271 | 194 | 185 | Yes |
| Reablement & Rehabilitation in a bedded setting | 51 | 47 | 50 | 56 | 43 | 47 | 55 | 53 | 47 | 56 | 44 | 56 | Yes |
| Other short-term social care | 5 | 11 | 12 | 12 | 11 | 8 | 9 | 7 | 9 | 12 | 11 | 11 | Yes |

# Better Care Fund 2024-25 Update Template

**5. Income**

Selected Health and Wellbeing Board: Dudley

| Local Authority Contribution | |
|---|---|
| Disabled Facilities Grant (DFG) | Gross Contribution |
| Dudley | £7,029,024 |
| | |
| DFG breakdown for two-tier areas only (where applicable) | |
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| | |
| **Total Minimum LA Contribution (exc iBCF)** | **£7,029,024** |

| Local Authority Discharge Funding | Contribution |
|---|---|
| Dudley | £3,885,297 |

| ICB Discharge Funding | Previously entered | Updated | Comments - Please use this box to clarify any specific uses or sources of funding |
|---|---|---|---|
| NHS Black Country ICB | £2,780,140 | £2,780,140 | |
| | | | |
| | | | |
| **Total ICB Discharge Fund Contribution** | £2,780,140 | £2,780,140 | |

| iBCF Contribution | Contribution |
|---|---|
| Dudley | £16,627,704 |
| | |
| **Total iBCF Contribution** | **£16,627,704** |

| Local Authority Additional Contribution | Previously entered | Updated | Comments - Please use this box to clarify any specific uses or sources of funding |
|---|---|---|---|
| Dudley | £15,822,293 | £24,079,855 | £5m DFG c/fwd, £3.2m inflation/demand pressure |
| | | | |
| | | | |
| **Total Additional Local Authority Contribution** | **£15,822,293** | **£24,079,855** | |

| NHS Minimum Contribution | Contribution |
|---|---|
| NHS Black Country ICB | £30,032,957 |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total NHS Minimum Contribution** | **£30,032,957** |

| Additional ICB Contribution | Previously entered | Updated | Comments - Please use this box clarify any specific uses or sources of funding |
|---|---|---|---|
| NHS Black Country ICB | £1,113,024 | £2,489,441 | |
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| **Total Additional NHS Contribution** | **£1,113,024** | **£2,489,441** | |
| **Total NHS Contribution** | **£31,145,981** | **£32,522,398** | |

| | 2024-25 |
|---|---|
| **Total BCF Pooled Budget** | **£86,924,419** |

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

**Better Care Fund 2024-25 Update Template**

**To Add New Schemes**

**6. Expenditure**

Selected Health and Wellbeing Board: Dudley

<< Link to summary sheet

| Running Balances | 2024-25 Income | Expenditure | Balance |
|---|---|---|---|
| DFG | £7,029,024 | £7,029,024 | £0 |
| Minimum NHS Contribution | £30,032,957 | £30,032,957 | £0 |
| iBCF | £16,627,704 | £16,627,704 | £0 |
| Additional LA Contribution | £24,079,855 | £24,079,855 | £0 |
| Additional NHS Contribution | £2,489,441 | £2,489,441 | £0 |
| Local Authority Discharge Funding | £3,885,297 | £3,885,297 | £0 |
| ICB Discharge Funding | £2,780,140 | £2,780,140 | £0 |
| **Total** | **£86,924,419** | **£86,924,418** | **£1** |

**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).

| | 2024-25 Minimum Required Spend | Planned Spend | Under Spend |
|---|---|---|---|
| NHS Commissioned Out of Hospital spend from the minimum ICB allocation | £8,534,515 | £11,141,241 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £18,891,716 | £18,891,716 | £0 |

**Checklist**

Column complete:

| Yes | Yes | Yes | Yes | Yes | Yes | | | | Yes | Yes | Yes | Yes | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

**>> Incomplete fields on row number(s):**

272, 273, 274, 275, 282, 284, 285

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Please specify if 'Scheme Type' is 'Other' | Previously entered Outputs for 2024-25 | Updated Outputs for 2024-25 | Units | Planned Expenditure: Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) | Provider | Source of Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1001 | Whole Population Prevention / Population Health | Locality Based Prevention Hubs | Community Based Schemes | Integrated neighbourhood services | | | 0 | | Social Care | | LA | | | Charity / Voluntary Sector | Additional LA Contribution |
| 1001 | Whole Population Prevention / Population Health | Locality Based Prevention Hubs - Carer support | Carers Services | Other | Locality Based Prevention Hubs - Carer support | 3500 | 3500 | Beneficiaries | Social Care | | LA | | | Charity / Voluntary Sector | Additional LA Contribution |
| 1002 | Whole Population Prevention / Population Health | Community Equipment Stores | Assistive Technologies and Equipment | Community based equipment | | 6618 | 6618 | Number of beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 1002 | Whole Population Prevention / Population Health | Community Equipment Stores | Assistive Technologies and Equipment | Community based equipment | | 7839 | 7839 | Number of beneficiaries | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 1003 | Whole Population Prevention / Population Health | Disabled Facilities Grant | DFG Related Schemes | Adaptations, including statutory DFG grants | | 500 | 300 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG |
| 1003 | Whole Population Prevention / Population Health | DFG - ASC Equipment Capital Costs | DFG Related Schemes | Discretionary use of DFG | | 8840 | 8840 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG |
| 1003 | Whole Population Prevention / Population Health | DFG - Net Zero Neighbourhood Scheme | DFG Related Schemes | Discretionary use of DFG | | 50 | 50 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG |
| 1003 | Whole Population Prevention / Population Health | DFG - Housing Assistance | DFG Related Schemes | Discretionary use of DFG | | 35 | 18 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1003 | Whole Population Prevention / Population Health | DFG - Minor Adaptations | DFG Related Schemes | Discretionary use of DFG | | 1850 | 2300 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG |
| 1003 | Whole Population Prevention / Population Health | DFG - Handypersons Capital Costs | DFG Related Schemes | Handyperson services | | 612 | 635 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG |
| 1003 | Whole Population Prevention / Population Health | DFG - Prior year carry forward | DFG Related Schemes | Adaptations, including statutory DFG grants | | 260 | 216 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 1004 | Whole Population Prevention / Population Health | Falls Service | Prevention / Early Intervention | Other | Falls service | | 0 | | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 1005 | Whole Population Prevention / Population Health | Careres Network Team | Carers Services | Other | Carer Advice and Support | 3500 | 3500 | Beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 2001 | Urgent Care Needs – Integrated Access | Out of Hours | Home-based intermediate care services | Reablement at home (accepting step up and step down users) | | 265 | 490 | Packages | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 2001 | Urgent Care Needs – Integrated Access | Out of Hours | Home-based intermediate care services | Reablement at home (accepting step up and step down users) | | 45 | 0 | Packages | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 2002 | Urgent Care Needs – Integrated Access | Access - SPOA | Integrated Care Planning and Navigation | Support for implementation of anticipatory care | | | 0 | | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 3001 | Ongoing Care Needs - Enhanced Primary & | Homecare | Home Care or Domiciliary Care | Domiciliary care packages | | 479629 | 492041 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Minimum NHS Contribution |
| 3001 | Ongoing Care Needs - Enhanced Primary & | Homecare | Home Care or Domiciliary Care | Domiciliary care packages | | 435118 | 431310 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | iBCF |
| 3001 | Ongoing Care Needs - Enhanced Primary & | Homecare | Home Care or Domiciliary Care | Domiciliary care packages | | 110948 | 232603 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Additional LA Contribution |
| 3003 | Ongoing Care Needs - Enhanced Primary & | Direct Payments | Personalised Budgeting and Commissioning | | | | 0 | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution |
| 3003 | Ongoing Care Needs - Enhanced Primary & | Direct Payments | Personalised Budgeting and Commissioning | | | | 0 | | Social Care | | LA | | | Private Sector | Additional LA Contribution |
| 3003 | Ongoing Care Needs - Enhanced Primary & | Direct Payments | Carers Services | Respite services | | 150 | 200 | Beneficiaries | Social Care | | LA | | | Private Sector | Minimum NHS Contribution |
| 3004 | Ongoing Care Needs - Enhanced Primary & | Urgent care assessment and therapy | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | | | 0 | | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 3004 | Ongoing Care Needs - Enhanced Primary & | Urgent care assessment and therapy | Integrated Care Planning and Navigation | Assessment teams/joint assessment | | | 0 | | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 4001 | Highest Care Needs – coordinated | Living independentley Team - Community Reablement | Home-based intermediate care services | Reablement at home (accepting step up and step down users) | | 3054 | 1563 | Packages | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 4001 | Highest Care Needs – coordinated | Living independentley Team - Community Reablement | Home-based intermediate care services | Reablement at home (accepting step up and step down users) | | 3054 | 1563 | Packages | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 4002 | Highest Care Needs – coordinated | Access & Prevention - Occupational Therapy | Prevention / Early Intervention | Other | Assessment for adaptations and preventative | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 4002 | Highest Care Needs – coordinated | Access & Prevention - Occupational Therapy | Prevention / Early Intervention | Other | Assessment for adaptations and preventative | | 0 | | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 4003 | Highest Care Needs – coordinated | Tiled House | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement (to support discharge) | | 306 | 306 | Number of placements | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 4004 | Highest Care Needs – coordinated | External reablement - packages of care | Home-based intermediate care services | Reablement at home (accepting step up and step down users) | | 1782 | 0 | Packages | Social Care | | LA | | | Private Sector | Minimum NHS Contribution |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4004 | Highest Care Needs – coordinated | Urgent Care - Homecare assistants | Urgent Community Response | | | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 4004 | Highest Care Needs – coordinated | Urgent Care - Homecare assistants | Urgent Community Response | | | | 0 | | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 4005 | Highest Care Needs – coordinated | Palliative - front end | Personalised Care at Home | Other | Palliative Care | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 4006 | Highest Care Needs – coordinated | Supported Living - MH | Home Care or Domiciliary Care | Domiciliary care packages | | 22076 | 19713 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Minimum NHS Contribution |
| 4006 | Highest Care Needs – coordinated | Supported Living - MH | Home Care or Domiciliary Care | Domiciliary care packages | | 144490 | 158695 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Additional LA Contribution |
| 4007 | Highest Care Needs – coordinated | Integrated Discharge Pathway | High Impact Change Model for Managing Transfer of Care | Other | Bed based Packages | | 0 | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution |
| 4007 | Highest Care Needs – coordinated | Short Term beds | Bed based intermediate Care Services (Reablement, | Other | Discharge 2 Assess | 48 | 48 | Number of placements | Social Care | | LA | | | Private Sector | Minimum NHS Contribution |
| 4007 | Highest Care Needs – coordinated | Short term beds | Bed based intermediate Care Services (Reablement, | Other | Discharge 2 Assess | 115 | | Number of placements | Social Care | | LA | | | Private Sector | iBCF |
| 4008 | Highest Care Needs – coordinated | Internal Day Care & Dementia Gateways | Community Based Schemes | Other | Internal Day Care & Dementia Gateways | | 0 | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 4009 | Highest Care Needs – coordinated | 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 |
| 4010 | Highest Care Needs – coordinated | Enhanced therapy offer | Home-based intermediate care services | Other | Preventing admissions to acute setting | 3054 | | Packages | Social Care | | LA | | | Local Authority | iBCF |
| 4011 | Highest Care Needs – coordinated | Enhanced review offer | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Social Care | | LA | | | Local Authority | iBCF |
| 4012 | Highest Care Needs – coordinated | Bed based Packages | Integrated Care Planning and Navigation | Other | Bed based Packages | | | | Social Care | | LA | | | Private Sector | iBCF |
| 4013 | Highest Care Needs – coordinated | DDS clients over 65 | Home Care or Domiciliary Care | Domiciliary care packages | | 98976 | | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | iBCF |
| 5001 | Discharge to Assess | Enhance the discharge to Assess model and increase capacity | Home Care or Domiciliary Care | Domiciliary care packages | | 37128 | 190518 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Local Authority Discharge |
| 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) | | 1272 | 0 | Packages | Social Care | | LA | | | Local Authority | Local Authority Discharge |
| 5002 | Additional Pathway 3 beds | To support discharge to assess to ensure that patients are transferred from | Residential Placements | Short-term residential/nursing care for someone likely to require a | | | 0 | Number of beds | Social Care | | LA | | | Private Sector | Local Authority Discharge |
| 5003 | Additional equipment | To reduce the number of resource for pathway 1 we require additional | Assistive Technologies and Equipment | Community based equipment | | 2544 | | Number of beneficiaries | Social Care | | LA | | | Local Authority | Local Authority Discharge |
| 5004 | Additional social work capacity for mental health and | 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 |
| 232501 | Tissue Viability Service | Provision of equipment to enable discharge of patients to their own home, | Assistive Technologies and Equipment | Community based equipment | | 1750 | 1750 | Number of beneficiaries | Community Health | | NHS | | | NHS | Minimum NHS Contribution |
| 232502 | Clinical Hub | 2 Hour Response and Admission Avoidance Service | Urgent Community Response | | | 37 | 37 | | Community Health | | NHS | | | NHS | Additional NHS Contribution |
| 232503 | Palliative and End of Life Care – dedicated | Dedicated Domiciliary Care providing end of life care to people in own homes | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 6 | 6 | | Community Health | | NHS | | | NHS | Minimum NHS Contribution |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | 2 | 2 | | Community Health | | NHS | | | NHS | Minimum NHS Contribution |
| 232505 | Long Term Conditions Nurses - Hospital | Long Term Conditions Nurses (Hospital Avoidance Team) | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | 10 | 10 | | Community Health | | NHS | | | NHS | Minimum NHS Contribution |
| 232506 | Pathway 2 Beds | Block Pathway 2 Capacity Intermediate/ Stepdown Care | Residential Placements | Short-term residential/nursing care for someone likely to require a | | | 40 | Number of beds | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution |
| 232507 | Additional Pathway 2 Beds capacity (ASCDF - | Additional bed based capacity to support acute discharges and maintain | Residential Placements | Short-term residential/nursing care for someone likely to require a | | | 11 | Number of beds | Community Health | | NHS | | | Private Sector | ICB Discharge Funding |
| 232508 | Pathway 3 Beds | Block Pathway 3 beds | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement (to support discharge) | | 37 | 19 | Number of placements | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution |
| 232509 | Pathway 2 Neuro Rehab Beds | Neuro-rehabilitation beds to aid discharge | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | | 29 | 38 | Number of placements | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution |
| 232510 | Pathway 2 Neuro Rehab Beds ASCDF | Additional bed based capacity to support acute discharges and maintain | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | | 2 | 0 | Number of placements | Community Health | | NHS | | | Private Sector | ICB Discharge Funding |
| 232511 | Intermediate Care Admission Avoidance Beds | Intermediate Care Admission Avoidance beds | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 23 | | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution |
| 232512 | District Nursing support into Intermediate Care | District Nursing support into Intermediate Care based at Tiled House. (Provider - | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 7564 | | Community Health | | NHS | | | NHS | Minimum NHS Contribution |
| 232513 | Additional Social Work Capacity (ASCDF Line 3) | To underpin ongoing work and to support discharges from community beds | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS Community Provider | ICB Discharge Funding |
| 232514 | Extra Intermediate Care Nurse capacity to | To meet demand within the acute setting and to expedite discharge from P2 | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | Private Sector | ICB Discharge Funding |
| 232515 | Pathway support | Working with partners across the system to provide capacity across all pathways | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 0 | | Community Health | | NHS | | | NHS | ICB Discharge Funding |
| 232516 | Pathway 2 Medical Support - (Doctor cover) | Doctor cover provision for patients in designated intermediate care homes. | Other | | Doctor to cover provision for patients in | | 0 | | Community Health | | NHS | | | NHS | Minimum NHS Contribution |
| 232517 | Medical input into stepdown facilities - | Medical input into stepdown facilities provided by DGFT (Included in the block - | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 0 | | Community Health | | NHS | | | NHS | Minimum NHS Contribution |
| 232519 | Pathway 2 Step Down Occupational | Pathway 2 Step down - Occupational Therapy Services based at Tiled | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 3165 | | Community Health | | NHS | | | NHS Acute Provider | Minimum NHS Contribution |
| 232520 | Pathway 2 Step Down Physiotherapy | Step Down Physiotherapy Services provided within Local Acute Community | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 3660 | | Community Health | | NHS | | | NHS | Minimum NHS Contribution |
| 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 | | | 0 | | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution |
| 232522 | Support for discharge | To provide increased capacity in discharge pathways. | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | 35 | | Community Health | | NHS | | | Private Sector | ICB Discharge Funding |
| 232523 | Pathway 2 beds | Block pathway 2 capacity Intermediate/Stepdown Care | Residential Placements | Multidisciplinary teams that are supporting independence, such as | | | 17 | Number of beds | Community Health | | NHS | | | Private Sector | Additional NHS Contribution |

# Adding New Schemes:

Back to top

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Please specify if 'Scheme Type' is 'Other' | | Outputs for 2024-25 | Units (auto-populate) | Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) (auto-populate) | Provider | Source of Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 232529 | Handy Person | Handy Person services to aid discharges from hospital back to own home | Personalised Care at Home | Physical health/wellbeing | | | | | Community Health | | NHS | | | Local Authority | ICB Discharge Funding |

| 232530 | High Intensity Service Users | Mental Health input into High Intensity Service Users to prevent admission | Urgent Community Response | | | | | | Community Health | | NHS | | | NHS Mental Health Provider | ICB Discharge Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 232531 | Community based Support | Additional support to aid timely discharge from hospital e.g. change locks, | Personalised Care at Home | Physical health/wellbeing | | | | | Community Health | | NHS | | | Local Authority | ICB Discharge Funding |
| 232532 | Community Based MH Support | Mental Health support for discharge based in community | Other | | Support for preventative services | | | | Community Health | | NHS | | | Local Authority | ICB Discharge Funding |
| 232524 | Additional Clinical Hub/OBI | Additional resource into Clincial Hub and OBI team within DGFT | Home-based intermediate care services | Reablement at home (to prevent admission to hospital or residential care) | | | 25 | Packages | Community Health | | NHS | | | NHS Community Provider | Additional NHS Contribution |
| 232525 | Own Bed Instead | Staffing for Own Bed Instead team within DMBC - aiding discharge | Home-based intermediate care services | Rehabilitation at home (to support discharge) | | | 0 | Packages | Community Health | | NHS | | | Local Authority | Additional NHS Contribution |
| 232526 | Care Home Brokerage Team | DMBC Care Home Brokerage Team - find homes for discharged patients | High Impact Change Model for Managing Transfer of Care | Improved discharge to Care Homes | | | | | Community Health | | NHS | | | Local Authority | Additional NHS Contribution |
| 232527 | Care Home Brokerage Team | DIHC Care Home Brokerage team - find homes for discharged patients | High Impact Change Model for Managing Transfer of Care | Improved discharge to Care Homes | | | | | Community Health | | NHS | | | NHS Community Provider | Additional NHS Contribution |
| 232528 | Discharge 2 Assess | D2A services, DMBC | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | | | | | Community Health | | NHS | | | Local Authority | Additional NHS Contribution |
| 1003 | DFG - Telecare Digital Switchover | DFG - Telecare Digital Switchover | DFG Related Schemes | Discretionary use of DFG | | | 2583 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | Additional LA Contribution |
| 5005 | LIT Duty increased TA support | 2FTE TA's supporting LIT Duty/Hospital Discharge | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Social Care | | LA | | | Local Authority | Local Authority Discharge |
| 4004 | Dudley STAR - Internal Reablement | Internal reablement - packages of care | Home-based intermediate care services | Reablement at home (accepting step up and step down users) | | | 1303 | Packages | Social Care | | LA | | | Local Authority | Minimum NHS Contribution |
| 5002 | Assessment beds | To support discharge to assess to ensure that patients are transferred from | Residential Placements | Short term residential care (without rehabilitation or reablement input) | | | 43 | Number of beds | Social Care | | LA | | | Private Sector | Local Authority Discharge |
| 5006 | Discharge to Assess - other acute hospitals | Increased capacity to aid 1 discharge per day from other hospitals | Home-based intermediate care services | Reablement at home (accepting step up and step down users) | | | 260 | Packages | Social Care | | LA | | | Local Authority | Local Authority Discharge |
| | | | | | | | | | | | | | | | |
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## Further guidance for completing Expenditure sheet

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

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

### 2023-25 Revised Scheme types

| Number | Scheme type/ services | Sub type | Description |
|---|---|---|---|
| 1 | Assistive Technologies and Equipment | 1. Assistive technologies including telecare<br>2. Digital participation services<br>3. Community based equipment<br>4. Other | Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services). |
| 2 | Care Act Implementation Related Duties | 1. Independent Mental Health Advocacy<br>2. Safeguarding<br>3. Other | Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF. |
| 3 | Carers Services | 1. Respite Services<br>2. Carer advice and support related to Care Act duties<br>3. Other | Supporting people to sustain their role as carers and reduce the likelihood of crisis.<br><br>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<br>2. Multidisciplinary teams that are supporting independence, such as anticipatory care<br>3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0)<br>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)<br><br>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<br>2. Discretionary use of DFG<br>3. Handyperson services<br>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.<br><br>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<br>2. System IT Interoperability<br>3. Programme management<br>4. Research and evaluation<br>5. Workforce development<br>6. New governance arrangements<br>7. Voluntary Sector Business Development<br>8. Joint commissioning infrastructure<br>9. Integrated models of provision<br>10. Other | Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes.<br><br>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<br>2. Monitoring and responding to system demand and capacity<br>3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge<br>4. Home First/Discharge to Assess - process support/core costs<br>5. Flexible working patterns (including 7 day working)<br>6. Trusted Assessment<br>7. Engagement and Choice<br>8. Improved discharge to Care Homes<br>9. Housing and related services<br>10. Red Bag scheme<br>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<br>2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)<br>3. Short term domiciliary care (without reablement input)<br>4. Domiciliary care workforce development<br>5. Other | A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services. |
| 9 | Housing Related Schemes | | This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units. |
| 10 | Integrated Care Planning and Navigation | 1. Care navigation and planning<br>2. Assessment teams/joint assessment<br>3. Support for implementation of anticipatory care<br>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.<br><br>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.<br><br>Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside. |
| 11 | Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery) | 1. Bed-based intermediate care with rehabilitation (to support discharge)<br>2. Bed-based intermediate care with reablement (to support discharge)<br>3. Bed-based intermediate care with rehabilitation (to support admission avoidance)<br>4. Bed-based intermediate care with reablement (to support admissions avoidance)<br>5. Bed-based intermediate care with rehabilitation accepting step up and step down users<br>6. Bed-based intermediate care with reablement accepting step up and step down users<br>7. Other | Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. |
| 12 | Home-based intermediate care services | 1. Reablement at home (to support discharge)<br>2. Reablement at home (to prevent admission to hospital or residential care)<br>3. Reablement at home (accepting step up and step down users)<br>4. Rehabilitation at home (to support discharge)<br>5. Rehabilitation at home (to prevent admission to hospital or residential care)<br>6. Rehabilitation at home (accepting step up and step down users)<br>7. Joint reablement and rehabilitation service (to support discharge)<br>8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)<br>9. Joint reablement and rehabilitation service (accepting step up and step down users)<br>10. Other | Provides support in your own home to improve your confidence and ability to live as independently as possible |
| 13 | Urgent Community Response | | Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. |
| 14 | Personalised Budgeting and Commissioning | | Various person centred approaches to commissioning and budgeting, including direct payments. |
| 15 | Personalised Care at Home | 1. Mental health /wellbeing<br>2. Physical health/wellbeing<br>3. Other | Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type. |
| 16 | Prevention / Early Intervention | 1. Social Prescribing<br>2. Risk Stratification<br>3. Choice Policy<br>4. Other | Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being. |
| 17 | Residential Placements | 1. Supported housing<br>2. Learning disability<br>3. Extra care<br>4. Care home<br>5. Nursing home<br>6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement<br>7. Short term residential care (without rehabilitation or reablement input)<br>8. Other | Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home. |
| 18 | Workforce recruitment and retention | 1. Improve retention of existing workforce<br>2. Local recruitment initiatives<br>3. Increase hours worked by existing workforce<br>4. Additional or redeployed capacity from current care workers<br>5. Other | These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work. |
| 19 | Other | | Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column. |

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

# Better Care Fund 2024-25 Update Template

**7. Narrative updates**

Selected Health and Wellbeing Board: Dudley

**Please set out answers to the questions below. No other narrative plans are required for 2024-25 BCF updates. Answers should be brief (no more than 250 words) and should address the questions and Key lines of enquiry clearly.**

## 2024-25 capacity and demand plan

Linked KLOEs (For information) — Checklist Complete:

**Please describe how you've taken analysis of 2023-24 capacity and demand actuals into account in setting your current assumptions.**

As a health and social care partnership we have reviewed our schemes and completed a Back-to-Basics review. Activity is monitored through BCF Executive where we can base our discussions to carry out forecasting for 24/25. Recently we have had a peer review from a local place to help Dudley model the required capacity for the next 12 months for all pathways.
Pathway 1 demand has increased over 23-24, and the demand now outweighs the capacity. There is work underway to support pathway 1 capacity such as utilising single handed equipment, but the financial challenges to increase capacity mean that further investment at this time is not possible.
The Clinical Hub has taken last year's 2023/24 activity and referrals to support planning assumptions for 2024/25. Planning assumptions include new work possibly from NHS 111 from September 2024, and the promotion work that has been taking place to increase referrals from all organisations to the clinical hub. Referrals over 23/24 have increased from primary care and care homes.

Pathway 2 capacity and demand modelling suggests a decrease in those patients requiring bedded rehabilitation with an assistance of one. Therefore, assumptions made are that capacity requirements for this

Checklist: Yes

Linked KLOE: Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions?

**Have there been any changes to commissioned intermediate care to address any gaps and issues identified in your C&D plan? What mitigations are in place to address any gaps in capacity?**

P2 has seen a recent reduction in admission figures for residential bedded rehabilitation for individuals who are assistance of one. Current workstreams are in place to scope initiatives for this facility and reduce spot purchase for P3 and non-weight bearing patients. P2 bedded rehabilitation are implementing initiatives to reduce current Length of Stay.

Checklist: Yes

Linked KLOE: Does the plan describe any changes to commissioned intermediate care to address gaps and issues?

Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the capacity needed for additional services?

**What impacts do you anticipate as a result of these changes for:**

**i. Preventing admissions to hospital or long term residential care?**

Local Authority provide support service for people with social care needs who are in a crisis to prevent a hospital admission. Therapy support and equipment is also provided to support the person through their period of recovery. We are looking at the introduction of the 'Ethel Care' model and continue to promote the single-handed care method to enable people to have equipment and techniques that support them with their daily care needs without the need of formal care.

Once NHS 111 pathways are established with the Urgent Community Response Service (UCRS) it should show a reduction in the unplanned attendances at the Emergency Department (ED) with an increase in patients being supported by our Community Services. The Falls response service delivered by our clinical HUB has been really successful in preventing admissions to hospital and our calls to the clinical hub from care homes and primary care has increased. Reinforcing the Home First model will hopefully result in less people going into Long term care. This will be a result of both using home first, but also providing intervention earlier on in the patients journey. For example the falls response service will provide falls interventions in the community at an earlier time, before the second fall.

Checklist: Yes

Linked KLOE: Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

**ii. Improving hospital discharges (preventing delays and ensuring people get the most appropriate support)?**

Joint working has meant the transfer of care document has been reviewed, refreshed, and will be implemented in the coming year. To improve communication and information and for it to be based in providing a full description of the patient's social care and therapy support, to allow a discharge to assess, assessment to take place in the person's own home. We will take the recommendations from the discharge peer support and Changeology to review our overall improvement plan.

Dudley Integrated Health Care have recently developed the patient passport for Pathway 2 bedded rehabilitation facilities, the passport is discussed and provided to individuals once accepted on Pathway 2. The document describes what individuals can expect from Pathway 2, it captures what the person wants to achieve and rehabilitation goals. The passport ensures individuals are at the centre of decision making and goal planning and offers individuals ownership and control of their journey through Pathway 2.

Checklist: Yes

Linked KLOE: Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?

**Please explain how assumptions for intermediate care demand and required capacity have been developed between local authority, trusts and ICB and reflected in BCF and NHS capacity and demand plans.**

Joint working with Dudley Metropolitan Borough Council (DMBC) and Dudley Integrated Health Care (DIHC) to implement new initiatives for a residential rehabilitation unit has taken place.
Assumptions made through capacity and demand monitoring suggests there is a trend for the number of individuals, who are assistance of one with no nursing needs, requiring a bedded rehabilitation bed is declining. This group of patients are now going home from hospital to continue their rehabilitation.

Joint working between the DMBC and DIHC have plans in place to use the rehabilitation unit more flexibly, working with staff within the unit and implement training where required. Pathway 3, and none weight bearing patients are now accessing this facility and therapy services when required. The expectation is that there will be a reduction in Pathway 3 spot purchase beds, focused resources, and an improved patient experience. We have worked together to create a 'patient passport' and following this Local Authority have revised and updated our internal therapy plans to use in the community with our Dudley STARs team.

Checklist: Yes

Linked KLOE: Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC activity templates and BCF capacity and demand plans?

**Have expected demand for admissions avoidance and discharge support in NHS UEC demand, capacity and flow plans, and expected demand for long term social care (domiciliary and residential) in Market Sustainability and Improvement Plans, been taken into account in you BCF plan?**

Yes

Checklist: Yes

**Please explain how shared data across NHS UEC Demand capacity and flow has been used to understand demand and capacity for different types of intermediate care.**

Intermediate Care have completed demand modelling based following discussions with NHSE colleagues, this has suggested a reduction in total of intermediate care beds. Some of the current block beds have been flexed for other pathways e.g. Pathway 3 to maximise efficiencies in community bed stock. Trends and activity is monitored monthly and is suggesting a reduction in those patients requiring bedded rehabilitation with assistance of one. This may be linked to OBI and Pathway 1 reablement; however, further analysis of OBI and Pathway 1 is required to substantiate this. The peer review recently completed will aid demand and capacity planning moving forward.

Checklist: Yes

Linked KLOE: Has the area described how shared data has been used to understand demand and capacity for different types of interme

## Approach to using Additional Discharge Funding to improve

**Briefly describe how you are using Additional Discharge Funding to reduce discharge delays and improve outcomes for people.**

Within the Local Authority a Dudley Short Term Assessment and Reablement Service (STARS) has been implemented. STARS offer a pathway 1 package of care (POC) to support with discharges, along with a reablement plan to allow patients to achieve their desired outcomes at home and return to their level of independence allowing flow within the system. Pathway 1 discharges are more coordinated and there is improved hospital flow whilst focusing on therapy and assisted technology.

A Social Work Project within Dudley Integrated Health Care has been established to support discharges from community beds, particularly at times of escalation, this innovative project commissions social workers on the basis of assessments completed, rather than short-term contracts and is managed through NHS Trust management. This has delivered improved times of assessment, reduced length of stay, and costs of community beds as well as improved outcomes of patients. Additional pathway 2 capacity has been commissioned specifically for specialised neuro rehabilitation, and an addition pathway 2 assessment nurse. Additional capacity has been commissioned for pathway 3. We have also provided further investment in housing type interventions. Experience has shown that some delays are due to

Checklist: Yes

Linked KLOE: Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan?

Is the plan for spending the additional discharge grant in line with grant conditions?

**Please describe any changes to your Additional discharge fund plans, as a result from**
- **Local learning from 23-24**
- **the national evaluation of the 2022-23 Additional Discharge Funding (Rapid evaluation of the 2022 to 2023 discharge funds - GOV.UK (www.gov.uk)**

Due to the success of the Social Work Project originally in 2023-24 which was for Pathway 3 only; this has now been extended across all Discharge To Assess (DTA) pathways to provide flexible support wherever demand dictates.

Having a dedicated provider for neuro rehabilitation community beds has allowed Multi Disciplinary Team (MDT) relationships to be developed.

Checklist: Yes

Linked KLOE: Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding?"

## Ensuring that BCF funding achieves impact

**What is the approach locally to ensuring that BCF plans across all funding sources are used to maximise impact and value for money, with reference to BCF objectives and metrics?**

Robust governance process in already in place for Dudley's BCF. A recent back to basics review of all spend lines, provided opportunity for funding objectives and outcomes to be scrutinised further, providing assurance and opportunities for further investment.

The development of a dedicated Joint BCF Programme Management Office (PMO) Team is now in place, the function of this team will strengthen current processes for monitoring and evaluating existing schemes providing assurance on progress against the metrics and value for money. The PMO Team has been established using existing resources in Dudley. Members of the BCF Executive includes representatives across the system and provides oversight of the BCF Programme.

1

Checklist: Yes

Linked KLOE: Does the BCF plan (covering all mandatory funding streams) provide reassurance that funding is being used in a way that supports the objectives of the Fund and contributes to making progress against the fund's metric?

## Better Care Fund 2024-25 Update Template

### 7. Metrics for 2024-25

Selected Health and Wellbeing Board: Dudley

### 8.1 Avoidable admissions

*Q4 Actual not available at time of publication

| | | 2023-24 Q1 Actual | 2023-24 Q2 Actual | 2023-24 Q3 Plan | 2023-24 Q4 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|---|
| Indirectly standardised rate (ISR) of admissions per 100,000 population<br><br>(See Guidance) | Indicator value | 311.0 | 271.5 | 236.0 | 241.7 | Next year's indicator values have been derived using current years actuals; with Q4 being estimated. These have increased from last year's plan due to increasing actual figures. Dudley has a high rate of older people and a high level of deprived areas. What we see at the front door is people presenting further down their disease trajectory and having more complex needs. Despite our continuous efforts to offer admission avoidance and prevention schemes, our rate of conveyances and admissions remains high. We continue to embed our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service and have seen an increase in referrals from Care Homes and GPs. Call before Convey for 60> is a new function, which enables the | The Clinical Hub is a vital element of admission avoidance and will continue to develop. All opportunities to work with partners to utilise the clinical hub will be explored, and expending the clinical hubs function with SDEC.<br>Admission avoidance will be supported by a newly commissioned mental health worker, the impact of this additional provision will be closely monitored.<br>An improvement programme will be agreed and implemented this summer; this plan will incorporate the recommendations from Discharge Improvement Week, Changeology C&D, BCF Back to Basics Review and the Virtual Ward GIRFT. The recommendations include:<br><br>• Improved communication and organisational integration by utilising |
| | Number of Admissions | 1,166 | 1,018 | - | - | | |
| | Population | 323,581 | 323,581 | - | - | | |
| | | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan | | |
| | Indicator value | 313.8 | 324.5 | 335.5 | 346.1 | | |

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

### 8.2 Falls

| | | 2023-24 Plan | 2023-24 estimated | 2024-25 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|
| Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | Indicator value | 2,341.2 | 1,656.7 | 1,426.2 | Next year's plan figures have decreased across all Local Authorities as current years actuals (so far to date) have decreased from planned values.<br><br>Falls in Dudley has an integrated pathway and a dedicated Falls Coordinator from Tier 0. A Falls front of house screening service is in place and aligns patients to the appropriate part of the Falls Pathway.<br><br>The Clinical Hub and OBI Teams work together around falls to urgently attend patients, avoid a hospital admission, and arrange | The Local Authority support the emergency EDT team and Telecare to respond to people who may have experienced falls and will provide an emergency POC via our teams who work 24/7. Falls pathway discharged 119 patients who were referred into the service from hospital in the 2023/24 financial year and it is likely to be a similar number during this next twelve months.<br><br>The Clinical Hub and OBI Teams work together around falls to urgently attend patients, avoid a hospital admission, and arrange ongoing therapy as appropriate. |
| | Count | 1,585 | 1129 | 971.94287 | | |
| | Population | 66,258 | 66258 | 66258 | | |

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

| | | 2023-24 Q1 Actual | 2023-24 Q2 Actual | 2023-24 Q3 Actual | 2023-24 Q4 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | Quarter (%) | 93.5% | 94.3% | 93.0% | 93.1% | Discharge to usual place of residence – Most areas are showing slight increases in plan due to increase during current year.<br><br>The complexity and acuity of patients going through our system is extremely high. The added demand of patients requiring admission to hospital means that people are being discharged maybe earlier than the ideal situation meaning that often people go into a care setting that is more dependent than required. Home First is the first approach, the Dudley Short Term Assessment and Reablement Service (STARS) has been implemented. | As part of the Changeology final report recommendations included a communication strategy. This will address issues with inconsistency of awareness surrounding the availability of wrap around resources in the community to support home first decisions within the discharge team.<br><br>To ensure full utilisation for OBI further to support care at home.<br><br>To continue to challenge to ensure out of area patients are discharged to their normal place of residence with minimal delay. |
| | Numerator | 6,535 | 6,608 | 6,299 | 6,300 | | |
| | Denominator | 6,990 | 7,008 | 6,770 | 6,768 | | |
| | | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan | | |
| | Quarter (%) | 93.6% | 94.3% | 93.2% | 93.1% | | |
| | Numerator | 6,782 | 6,796 | 6,803 | 6,604 | | |
| | Denominator | 7,244 | 7,203 | 7,302 | 7,093 | | |

## 8.4 Residential Admissions

| | | 2022-23 Actual | 2023-24 Plan | 2023-24 estimated | 2024-25 Plan | Rationale for how the ambition for 2024-25 was set. Include how learning and performance to date in 2023-24 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area. | Please describe your plan for achieving the ambition you have set, and how BCF funded services support this. |
|---|---|---|---|---|---|---|---|
| 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 | 540.3 | 798.2 | 415.4 | 353.4 | We have seen a reduction within our metrics for 24/25 as we have since 23/24 implemented support programmes within the Local Authority which will support the 'home first' ethos, with the introduction of the Dudley Stars team, we are able to support with more packages of care and clients having their care needs met at home rather than in a residential home. | Implementation of the Dudley STARS team will continue to support the 'home first' model where clients will be assessed and supported via therapy interventions and can return to their own level of independence within their own home.<br><br>The introduction of the Pathway 2 patient passport will enable more |
| | Numerator | 358 | 540 | 281 | 241 | | |
| | Denominator | 66,258 | 67,649 | 67,649 | 68,200 | | |

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

Please note, actuals for Cumberland and Westmorland and Furness are using the Cumbria combined figure for the Residential Admissions metrics since a split was not available; Please use comments box to advise.

| | Code | 2023-25 Planning Requirement | Key considerations for meeting the planning requirement<br>These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) to be confirmed for 2024-25 plan updates | Confirmed through |
|---|---|---|---|---|
| NC1: Jointly agreed plan | **PR1** | **A jointly developed and agreed plan that all parties sign up to** | Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* | Cover sheet |
| | | | Has the HWB approved the plan/delegated (in line with the Health and Wellbeing Board's formal governance arrangements) approval?<br>**Paragraph 11 as stated in BCF Planning Requirements 2023-25* | Cover sheet |
| | | | Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* | Cover sheet |
| | | | Have all elements of the Planning template been completed? *Paragraph 11* | Cover sheet |
| | Not covered in plan update - please do not use | **A clear narrative for the integration of health, social care and housing** | Not covered in plan update | |
| | **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? | Cover sheet |
| | | | In two tier areas, has:<br>- Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or<br>- The funding been passed in its entirety to district councils? | Planning Requirements |

| | | | | |
|---|---|---|---|---|
| NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer | **PR4 & PR6** | **A demonstration of how the services the area commissions will support the BCF policy objectives to:**<br><br>**- Support people to remain independent for longer, and where possible support them to remain in their own home**<br><br>**- Deliver the right care in the right place at the right time?** | Has the plan (including narratives, expenditure plan and intermediate care capacity and demand template set out actions to ensure that services are available to support people to remain safe and well at home by avoiding admission to hospital or long-term residential care and to be discharged from hospital to an appropriate service?<br><br>Has the area described how shared data has been used to understand demand and capacity for different types of intermediate care?<br><br>Have gaps and issues in current provision been identified?<br><br>Does the plan describe any changes to commissioned intermediate care to address these gaps and issues?<br><br>Does the plan set out how demand and capacity assumptions have been agreed between local authority, trusts and ICB and reflected these changes in UEC demand, capacity and flow estimates in NHS activity operational plans and BCF capacity and demand plans?<br><br>Does the HWB show that analysis of demand and capacity secured during 2023-24 has been considered when calculating their capacity and demand assumptions? | |
| Additional discharge funding | **PR5** | **A strategic, joined up plan for use of the Additional Discharge Fund** | Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges?<br><br>Does this plan contribute to addressing local performance issues and gaps identified in the areas capacity and demand plan?<br><br>Does the plan take into account learning from the impact of previous years of ADF funding and the national evaluation of 2022/23 funding? | |
| NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time | **PR6** | **A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time** | PR 4 and PR6 are dealt with together (see above) | |
| NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services | **PR7** | **A demonstration of how the area will maintain the level of spending on social care services and NHS commissioned out of hospital services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution** | Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution?<br><br>Does the total spend from the NHS minimum contribution on NHS commissioned out of hospital services match or exceed the minimum required contribution? | |

| | | | | |
|---|---|---|---|---|
| Agreed expenditure plan for all elements of the BCF | **PR8** | **Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?** | Do expenditure plans for each element of the BCF pool match the funding inputs?<br><br>Where there have been significant changes to planned expenditure, does the plan continue to support the BCF objectives?<br><br>Has the area included estimated amounts of activity that will be delivered/funded through BCF funded schemes? (where applicable)<br><br>Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend?<br><br>Is there confirmation that the use of grant funding is in line with the relevant grant conditions?<br><br>Has the Integrated Care Board confirmed distribution of its allocation of Additional Discharge Fund to individual HWBs in its area?<br><br>Has funding for the following from the NHS contribution been identified for the area:<br>- Implementation of Care Act duties?<br>- Funding dedicated to carer-specific support?<br>- Reablement? Paragraph 12 | |
| Metrics | **PR9** | **Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?** | Is there a clear narrative for each metric setting out:<br>- supporting rationales that describes how these ambitions are stretching in the context of current performance?<br>- plans for achieving these ambitions, and<br>- how BCF funded services will support this? | |

APPENDIX 3

NHS
Black Country
Integrated Care Board
Business Intelligence Team

# Report : Dudley Place Better Care Fund Metrics

## Date : March 2024 (Reporting January 2024 Secondary Care Data*, March 2024 Intermediate Care Data, March 2024 Clinical Hub Data, January 2024 Urgent Community Response Data, February 2024 Crisis Response Team Data and, March 2024 Hub Falls Activity Data)

*Secondary Care Falls Data has not been published beyond Jan 24

# Metric Definitions

Source : The Better Care Exchange

NHS Black Country Integrated Care Board Business Intelligence Team

### Metric 1: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population. Collected Annually.

**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.
**Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from the Short- and Long-Term Support (SALT) return, collected by NHS England. **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.

### Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. Collected Annually.

The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for reablement or rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of in scope discharges. **Denominator:** Number of in scope discharges.

### Metric 3: Unplanned hospitalisation for chronic ambulatory care sensitive conditions. Collected Monthly by Central BCF Team, published on Better Care Exchange.

This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The **numerator** is given by the number of finished and unfinished ***admission episodes***, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema. Because the **denominator** for the official published measure (***mid-year population estimates*** for England published by the Office for National Statistics (ONS) are only available in June following the end of year in question, baseline data provided in the BCF template uses mid-year estimates for 2020-21 as a denominator).

### Metric 4: Discharge to usual place of residence. Collected Monthly by Central BCF Team, published on Better Care Exchange.

This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Maximising the proportion of people who return to their usual place of residence at the point of discharge enables more people to live independently at home. This indicator measures the percentage of discharges that are to a person's usual place of residence.
**Numerator:** The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person's usual place of residence. **Denominator:** All completed hospital spells recorded in SUS for people over the age of 18 – calculation on monthly total. Does not include Same Day Emergency Care (Zero day) admissions.

### Metric 5: Metric 5: Reducing the number of emergency hospital admissions due to falls in people over 65

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, This indicator is an important measure around joint working between adult social care and health partners (e.g. urgent community response services) to prevent hospital admissions and reduce falls which will improve outcomes for older people and support independence.
**Numerator:** Emergency admissions for falls injuries for people over the age of 65, classified by primary diagnosis code (ICD10 code S00 to T98) and external cause (ICD10 code W00 to W19) and an emergency admission code (episode order number equals 1, admission method starts with 2). **Denominator:** Local Authority level estimates of resident population aged 65 and over.

# Metrics 1 and 2 - Supporting the long terms needs of older people

Source : Local Authority Colleagues

Period : Q1 2022/23 : Q4 2022/23

Local Authority metrics are collected on a quarterly basis as the 91 day metric does not lend itself to monthly monitoring. These are local monitoring figures, the official metrics are collected annually.

| HWB Name | Period | 1a. Admissions to residential and care homes – 18-64 (per 100,000 pop) | 1b. Admissions to residential and care homes – 65+ (per 100,000 pop) | 2. Proportion of people aged 65+ discharged who are still at home after 91 days |
|---|---|---|---|---|
| Dudley | 2022/23 Q1 | 6.40 | 457 | 0.98 |
| Dudley | 2022/23 Q2 | 10.70 | 503 | 0.90 |
| Dudley | 2022/23 Q3 | 11.00 | 619 | 0.88 |
| Dudley | 2022/23 Q4 | 11.00 | 533 | 0.88 |

# Metric 3 Dudley Avoidable (Chronic Ambulatory Care Sensitive) Admissions

Source : Data Published on Better Care Exchange
Period : October 2022 : January 2024

NHS Black Country Integrated Care Board Business Intelligence Team

The count of observed avoidable admissions has increased markedly from Q3 of 2022/23 and this increased level of activity is the new norm.

Using crude rates per 1,000 population to benchmark the ICB's four places, Dudley's has markedly worsened, although there has been some improvement in recent months. However, it should be noted that the average rate per 1,000 population has also increased elsewhere which would tend to suggest that the coding change is not the only reason for the Dudley increase.

The red lines on the chart are the upper and lower control limits, data points beyond these (marked as red) should be considered to be outside the "normal" range of variation.

### Average Rate in Reported Period

| HWB Name | Ave Rate / 1,000 Pop |
|---|---|
| Dudley | 1.15 |
| Sandwell | 1.00 |
| Walsall | 1.24 |
| Wolverhampton | 1.14 |

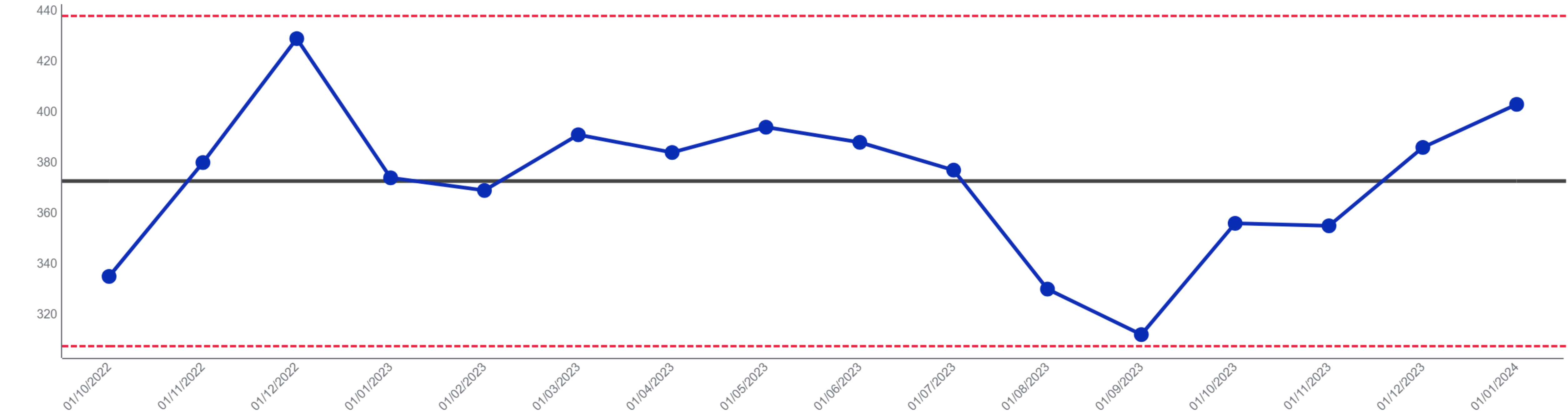
### Average Rate in Last Three Months

| HWB Name | Ave Rate / 1,000 Pop |
|---|---|
| Dudley | 1.18 |
| Sandwell | 1.05 |
| Walsall | 1.37 |
| Wolverhampton | 1.21 |

### Rate in Latest Reported Month

| HWB Name | Rate / 1,000 Pop |
|---|---|
| Dudley | 1.25 |
| Sandwell | 1.04 |
| Walsall | 1.30 |
| Wolverhampton | 1.31 |

### Observed Admissions



# Metric 4 Dudley Patients Discharged to Usual Residence (DTUR)

Source : Data Published on Better Care Exchange

Period : October 2022 : January 2024

NHS Black Country Integrated Care Board Business Intelligence Team

The generally accepted ambition for the proportion of patients discharged to their usual residence is 95%, a figure that has not been achieved in Dudley in the monitored period. Only Walsall consistently averages 95%. Recent months have seen some improvement in this metric for Dudley Place.

The red lines on the chart are the upper and lower control limits, data points beyond these (marked as red) should be considered to be outside the "normal" range of variation.

## Average DTUR in Reported Period

| HWB Name | Ave % DTUR |
|---|---|
| Dudley | 93.17% |
| Sandwell | 94.20% |
| Walsall | 95.57% |
| Wolverhampton | 93.20% |

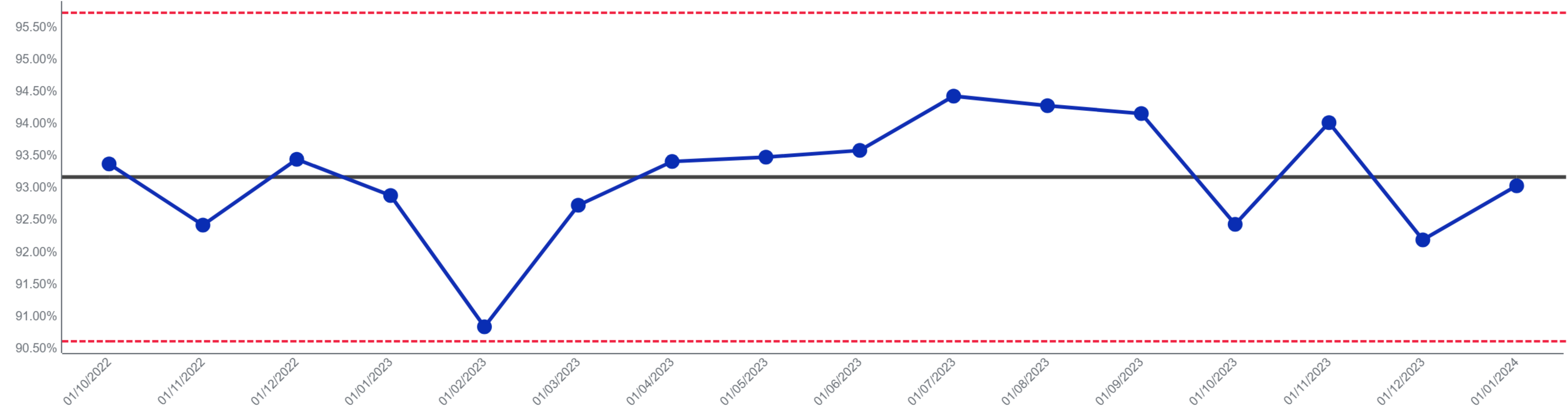
## Average DTUR in Last Three Months

| HWB Name | Ave % DTUR |
|---|---|
| Dudley | 93.08% |
| Sandwell | 94.00% |
| Walsall | 95.61% |
| Wolverhampton | 93.53% |

## DTUR in Latest Reported Month

| HWB Name | Ave % DTUR |
|---|---|
| Dudley | 93.03% |
| Sandwell | 94.22% |
| Walsall | 95.38% |
| Wolverhampton | 92.97% |

## Trend in the Proportion of Spells Discharged to Usual Residence



# Metric 5 Dudley Patients Aged 65 and Over Admissions Coded to Falls

Source : Data Published on Better Care Exchange
Period : October 2022 : December 2023

NHS Black Country Integrated Care Board Business Intelligence Team

The count of observed falls admissions increased markedly between October 2022 and January 2023 but has since fallen back to levels seen in earlier months. Nevertheless, falls admissions have been on an upwards trajectory from the start of the monitored period. The falls data is subject to considerable latency.

The increase between October 2022 and January 2023 was due to increased pressures during winter months. Admissions decreased substantially early 2023. It is worth noting that in terms of standardised rates, Dudley's performance is better than the ICB average.

The red lines on the chart are the upper and lower control limits, data points beyond these (marked as red) should be considered to be outside the "normal" range of variation.

### Average DSR in Reported Period

| Organisation | Average |
|---|---|
| Dudley | 170.11 |
| Sandwell | 174.04 |
| Walsall | 213.88 |
| Wolverhampton | 253.95 |

| Organisation | Average |
|---|---|
| ICB | 199.02 |

### Average DSR in Last 3 Months

| Organisation | Average |
|---|---|
| Dudley | 161.72 |
| Sandwell | 160.46 |
| Walsall | 192.54 |
| Wolverhampton | 255.62 |

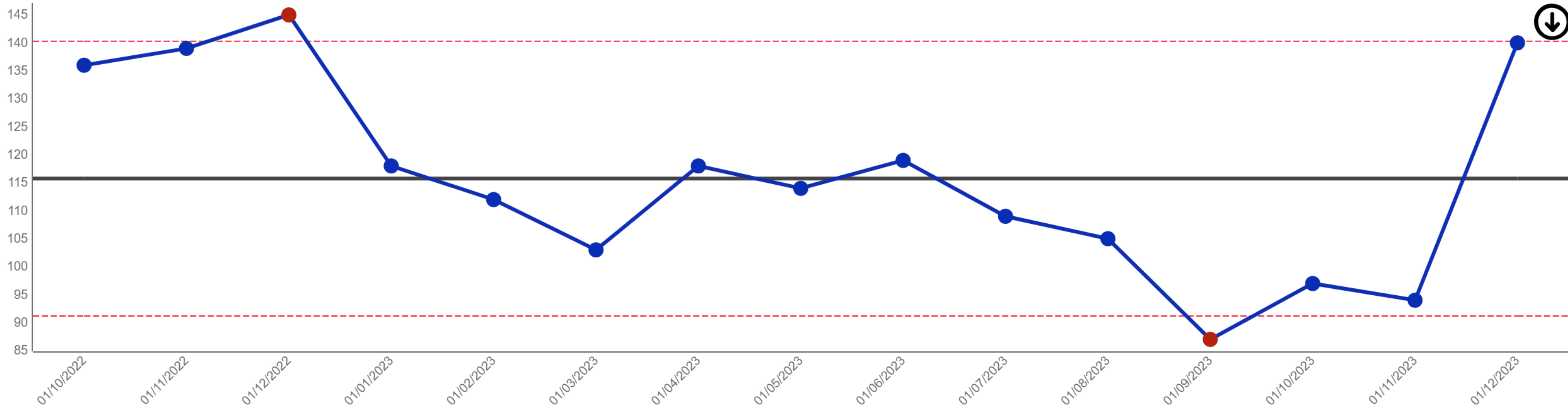
| Organisation | Average |
|---|---|
| ICB | 188.30 |

### Average DSR in Latest Month

| Organisation | Average |
|---|---|
| Dudley | 206.01 |
| Sandwell | 152.12 |
| Walsall | 210.85 |
| Wolverhampton | 245.81 |

| Organisation | Average |
|---|---|
| ICB | 202.91 |

### Observed Admissions



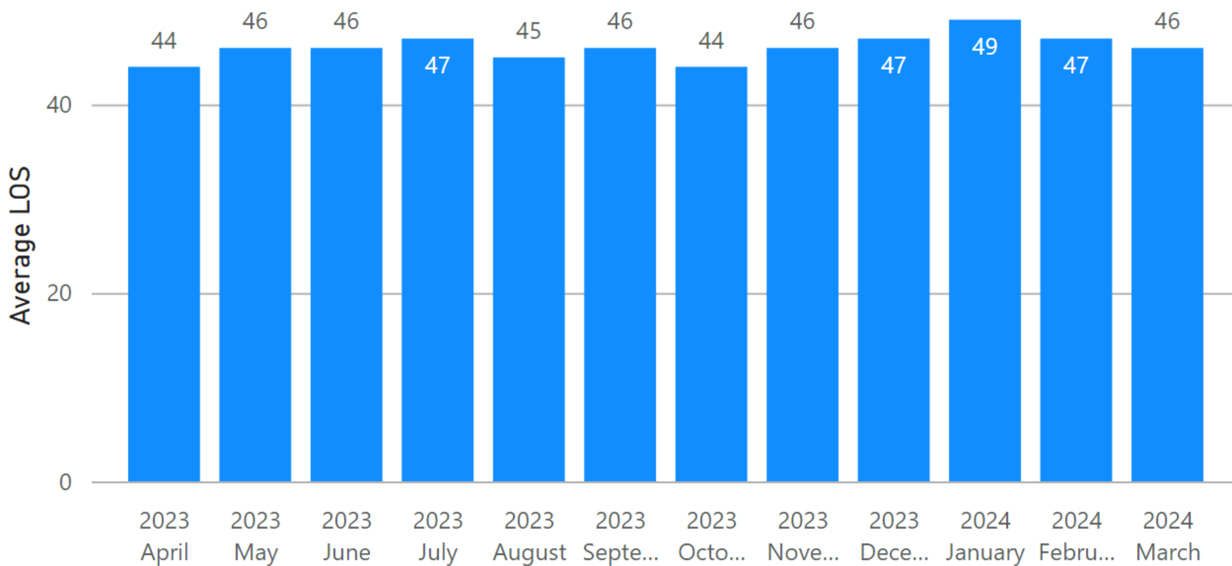
# Dudley Intermediate Care Metrics

Source : Intermediate Care Service

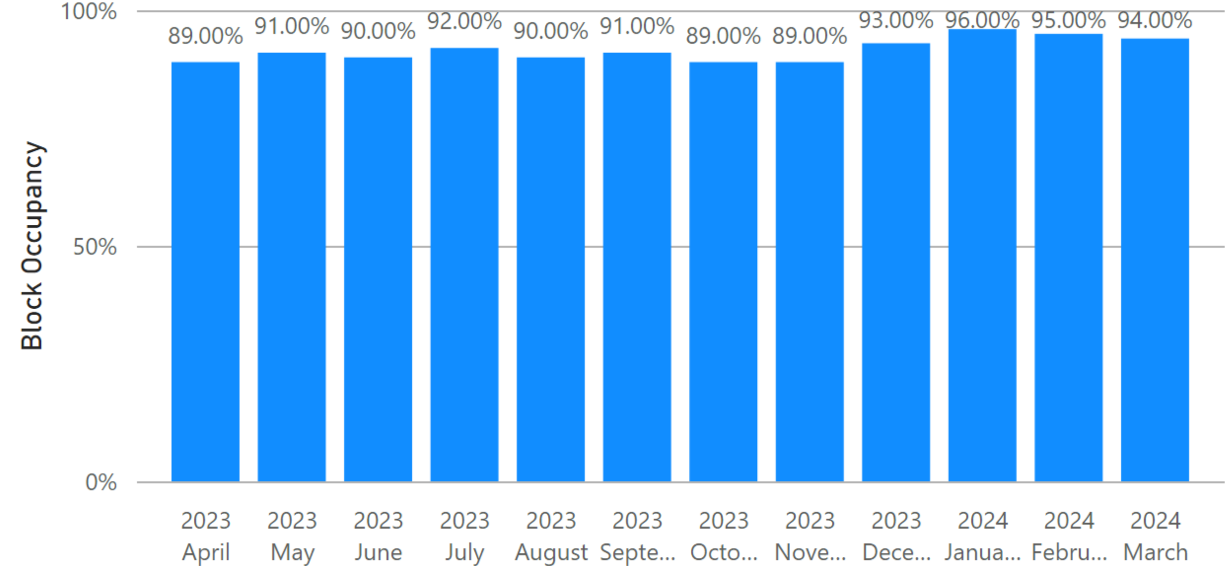
Period : April 2023 : March 2024

NHS Black Country Integrated Care Board Business Intelligence Team

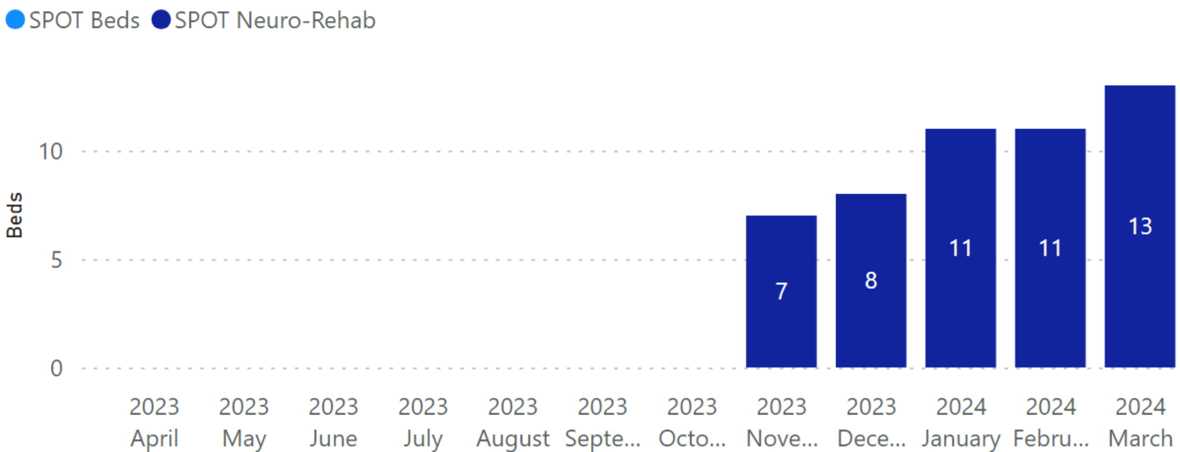
## Average Length of Stay (LOS) by Month




## Block Bed Occupancy by Month




## SPOT Beds Commissioned by Month




## *Commentary*

**Average Length of Stay** - the ambition is to achieve an average LOS of 28 to 42 days (Intermediate Care Framework). Multiple projects have been established to reduce average LOS in Dudley.

**Block Bed Occupancy** - the current model allows flexibility within pathways and prevents unnecessary hospital admissions.

**SPOT Beds Commissioned** - no SPOT purchased capacity has been required; patient flow has been managed through the substantive bed stock.

**SPOT Neuro-Rehab Beds Commissioned** - SPOT purchased Neuro-Rehab capacity is required when West Park is unable to accommodate a patient.

# Dudley Clinical Hub Triage - Telephone Referrals

Source : Dudley Clinical Hub
Period : January 2023 : March 2024

NHS Black Country Integrated Care Board Business Intelligence Team

## Total Telephone Referrals

Referrals
2000
1500
2023 January
2023 February
2023 March
2023 April
2023 May
2023 June
2023 July
2023 August
2023 September
2023 October
2023 November
2023 December
2024 January
2024 February
2024 March

## Telephone Referrals by Source

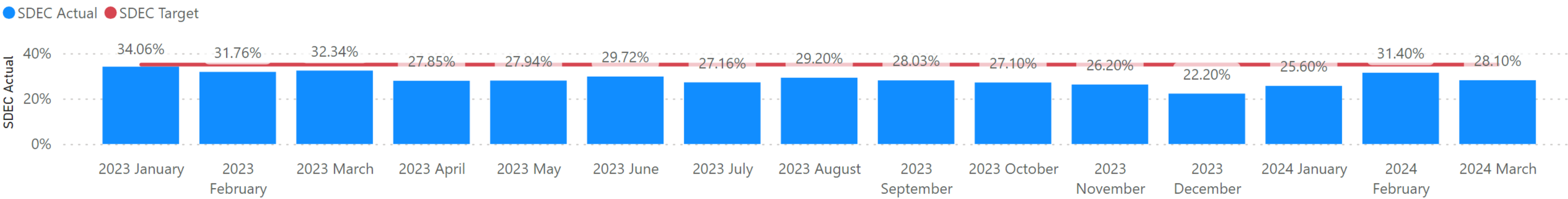
| Referral Source | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [A] GP REFERRALS | 648 | 554 | 616 | 443 | 574 | 668 | 564 | 569 | 567 | 624 | 588 | 493 | 615 | 642 | 576 |
| [B] WMAS REFERRALS | 229 | 187 | 210 | 207 | 196 | 203 | 230 | 227 | 148 | 204 | 186 | 267 | 264 | 235 | 175 |
| [C] 111 | 22 | 32 | 40 | 30 | 18 | 12 | 11 | 26 | 24 | 22 | 17 | 24 | 25 | 17 | 28 |
| [D] CARE HOME REFERRALS | 552 | 459 | 476 | 539 | 560 | 509 | 535 | 545 | 640 | 695 | 709 | 781 | 811 | 618 | 717 |
| [E] OTHER | 342 | 293 | 280 | 197 | 335 | 448 | 468 | 395 | 504 | 569 | 524 | 502 | 524 | 494 | 539 |
| **Total** | **1793** | **1525** | **1622** | **1416** | **1683** | **1840** | **1808** | **1762** | **1883** | **2114** | **2024** | **2067** | **2239** | **2006** | **2035** |

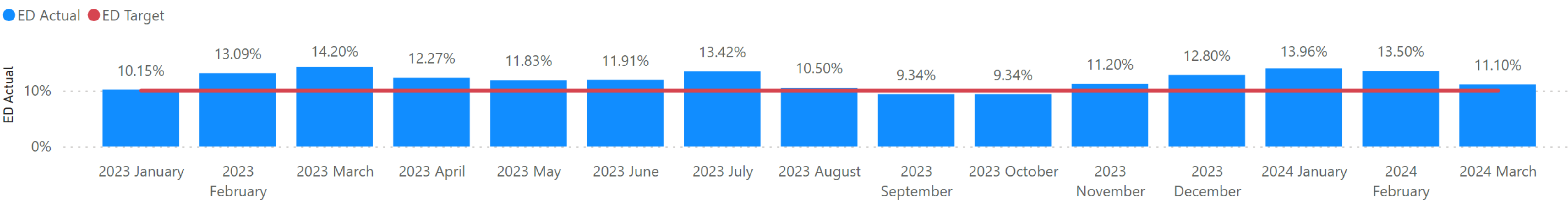
## Telephone Referrals by Source %

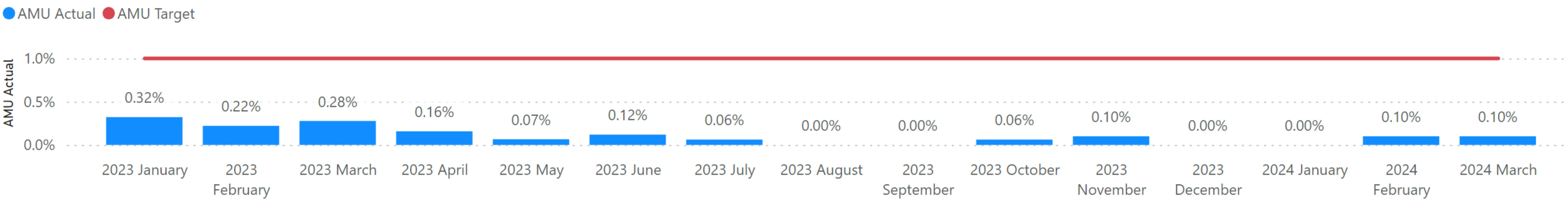
| Referral Source | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [A] GP REFERRALS | 36.14% | 36.33% | 37.98% | 31.29% | 34.11% | 36.30% | 31.19% | 32.29% | 30.11% | 29.52% | 29.05% | 23.85% | 27.47% | 32.00% | 0 |
| [B] WMAS REFERRALS | 12.77% | 12.26% | 12.95% | 14.62% | 11.65% | 11.03% | 12.72% | 12.88% | 7.86% | 9.65% | 9.19% | 12.92% | 11.79% | 11.71% | 0 |
| [C] 111 | 1.23% | 2.10% | 2.47% | 2.12% | 1.07% | 0.65% | 0.61% | 1.48% | 1.27% | 1.04% | 0.84% | 1.16% | 1.12% | 0.85% | 0 |
| [D] CARE HOME REFERRALS | 30.79% | 30.10% | 29.35% | 38.06% | 33.27% | 27.66% | 29.59% | 30.93% | 33.99% | 32.88% | 35.03% | 37.78% | 36.22% | 30.81% | 0 |
| [E] OTHER | 19.07% | 19.21% | 17.26% | 13.91% | 19.90% | 24.35% | 25.88% | 22.42% | 26.77% | 26.92% | 25.89% | 24.29% | 23.40% | 24.63% | 0 |
| **Total** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **0** |

# Dudley Clinical Hub Triage - Outcome Metrics SDEC, ED, AMU

Source : Dudley Clinical Hub
Period : January 2023 : March 2024



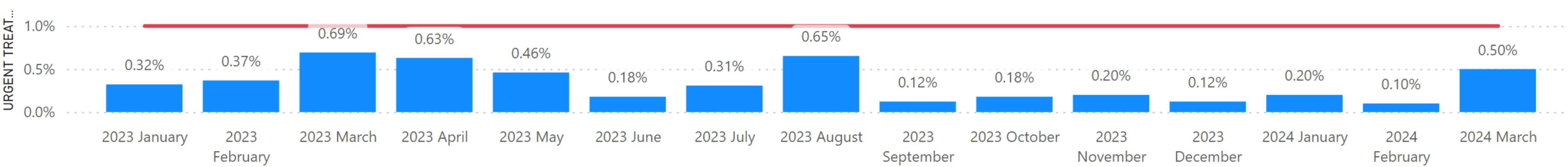
# Dudley Clinical Hub Triage - Outcome Metrics UTC, Community, Other

Source : Dudley Clinical Hub

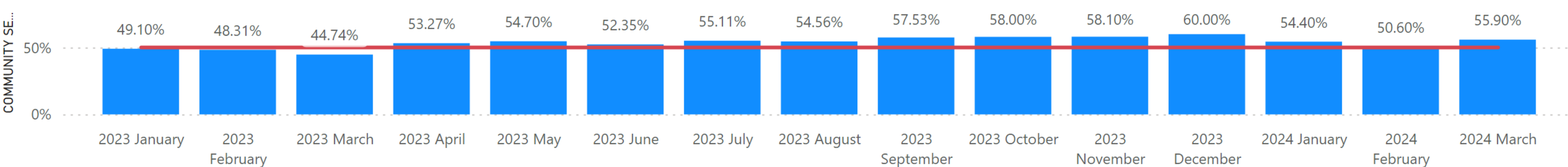
Period : January 2023 : March 2024

NHS Black Country Integrated Care Board Business Intelligence Team

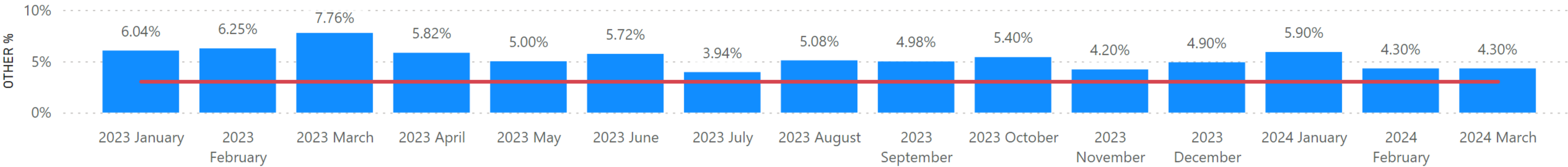
## Outcome UTC (Target below 1%)




## Outcome Community Services (Target above 50%)



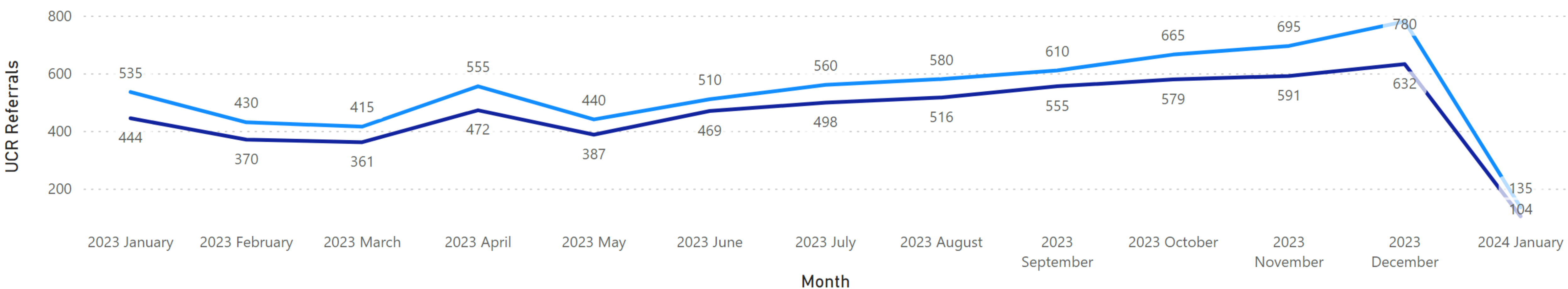

## Outcome Other (Target above 3%)

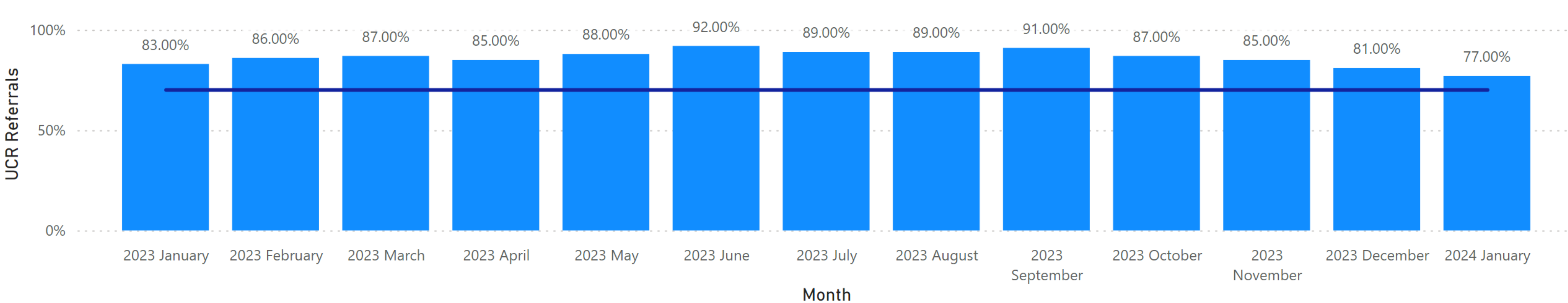


# Dudley Clinical Hub Triage - Urgent Community Response (UCR) Metric

Source : Dudley Clinical Hub
Period : January 2023 : January 2024

NHS Black Country Integrated Care Board Business Intelligence Team



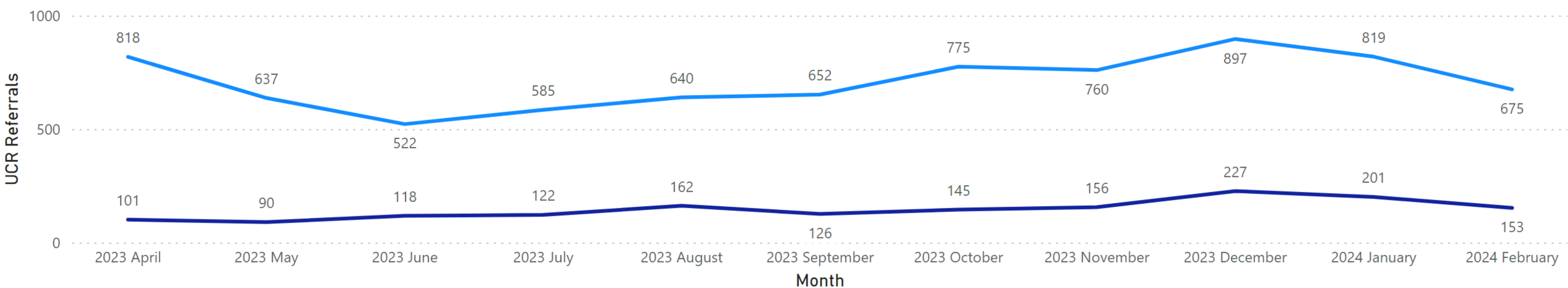
# Dudley Clinical Hub Triage - Crisis Response Team (CRT) Metric

Source : Dudley Clinical Hub

Period : April 2023 : February 2024

NHS Black Country Integrated Care Board Business Intelligence Team

## Number of Emergency admissions via CRT Visits




## CRT Visits - % resulting in hospital admission avoidance within 28 days (Target to be confirmed)

UCR Referrals

80%

60%

40%

20%

0%

| Month | % |
|---|---|
| 2023 April | 87.65% |
| 2023 May | 85.87% |
| 2023 June | 77.39% |
| 2023 July | 79.15% |
| 2023 August | 74.69% |
| 2023 September | 80.67% |
| 2023 October | 81.29% |
| 2023 November | 79.47% |
| 2023 December | 74.69% |
| 2024 January | 75.46% |
| 2024 February | 77.33% |

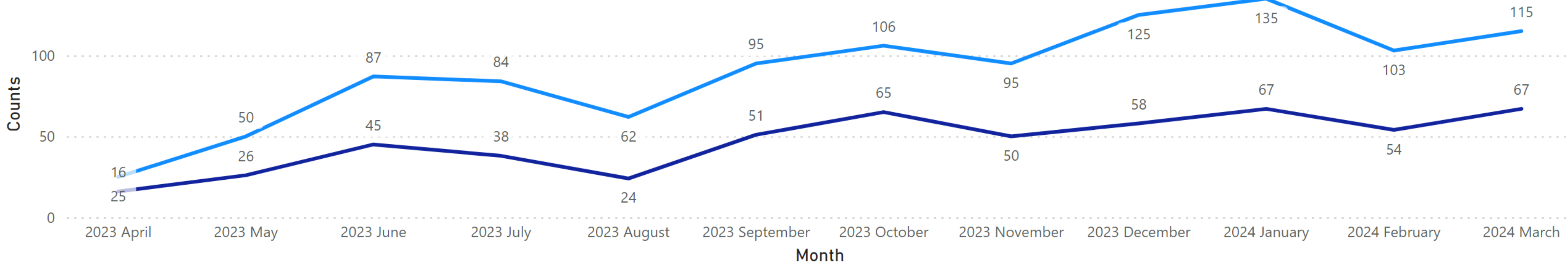
Month

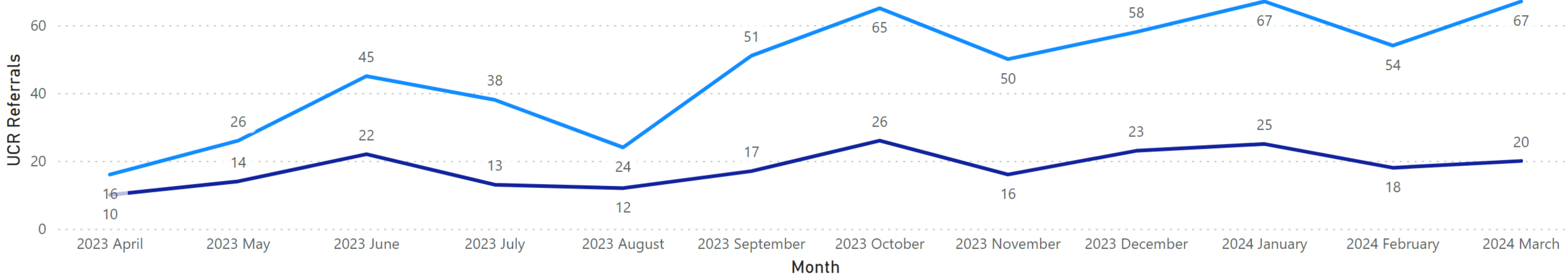
# Dudley Clinical Hub Falls Calls, UCR Visits and patients picked up from floor

Source : Dudley Clinical Hub

Period : April 2023 : March 2024

NHS Black Country Integrated Care Board Business Intelligence Team

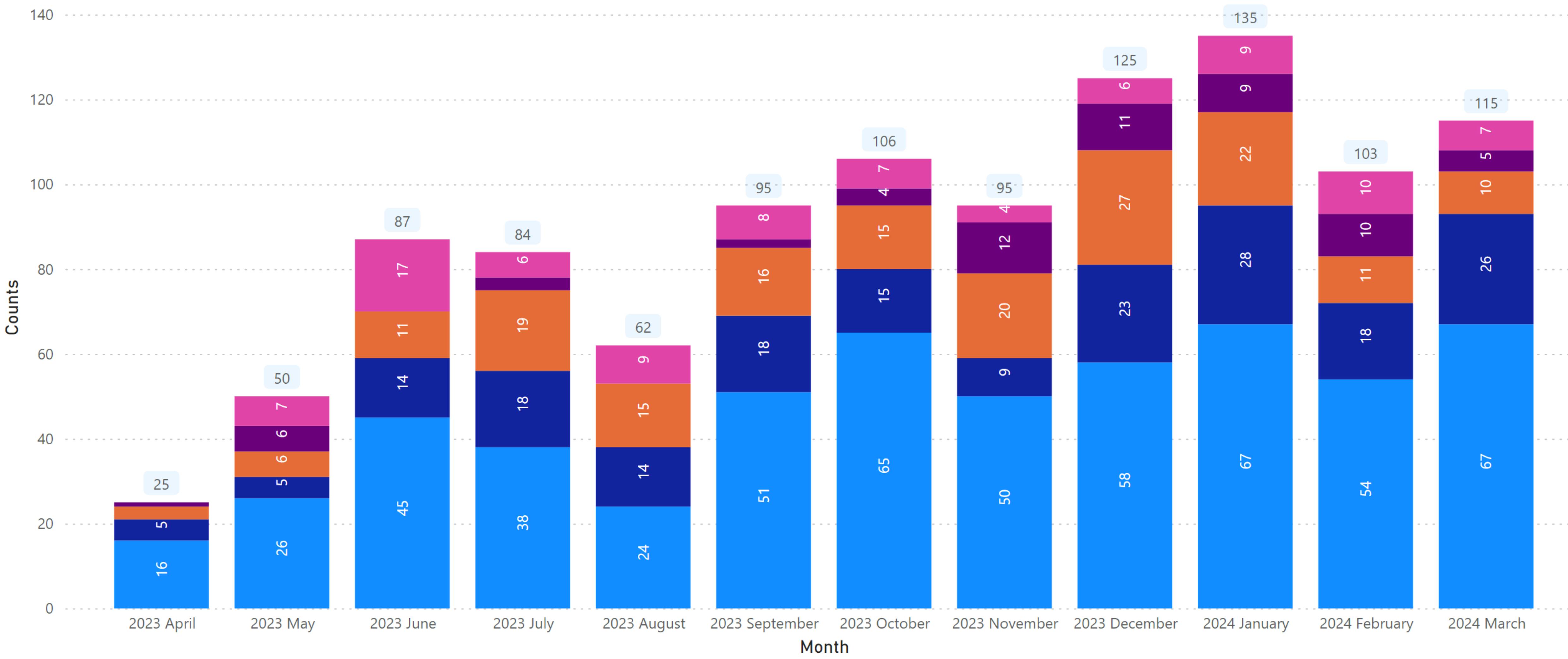


# Dudley Clinical Hub Falls Calls and Call Outcomes

Source : Dudley Clinical Hub
Period : April 2023 : March 2024

NHS Black Country Integrated Care Board Business Intelligence Team



**Better Care Fund Plan 2023-25 – Update 2024 - 25**

On 28 March 2024 the Government and NHS England published an addendum to the Better Care Fund (BCF) Policy Framework and Planning Requirements for 2023-25, which set out guidance for completing updates to BCF plans for 2024-25.

The fundamental intention of the Plan is to integrate services across health and care to: -

- prevent unnecessary admission to hospital;
- prevent unnecessary admission to care homes;
- enable safe and timely discharge and rehabilitation;
- enable people to live independently in their communities.

The national conditions and planning requirements set out in the original 2-year requirements remain. Areas will be expected to update discharge plans, set metrics and capacity and demand estimates for 2024-25, and to confirm plans for BCF spending based on final allocations.

For the 2023-25 BCF submission, a comprehensive narrative plan accompanies our submission. This was approved by the Health and Well Being Board in June 2023. For the purpose of the 2024-25 submission, we have reviewed our 2023-25 plan and provided updates and will refresh this plan over the summer of 2024 following a series of workshops to agree ongoing priorities. This document provides an update on progress relating to our 2023-25 plan. The Better Care Fund Metrics can be Found in Appendix1, other system performance metrics can be found in Appendix 2.

**2023-24 Updates**

- We continue to embed our **Clinical Hub**, Urgent Community Response (UCR) as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service. We are seeing an increase in calls from care homes and GPs. Call before convey has commenced and there is ongoing work with West Midlands Ambulance Service to fully utilise the admission avoidance function when appropriate. In May 2024 West Midlands Ambulance Service changed their criteria to reduce the age that crews can call admission avoidance teams from 75 to 60, so we are hopeful this has an impact on calls to the Clinical Hub. We are still struggling to increase the numbers of calls from the Ambulance Service but overall, we are seeing increased usage of the Clinical Hub 2-hour response.

  The UCR team report that although the total number of referrals increased during 23-24, there has been little impact on the number of referrals from the Ambulance Service despite call before convey.

- Dudley Clinical Hub launched the boroughs first “Clinical Falls Pickup Community Service” on April 23rd, 2023. This is service is provided through

the upskilling of current clinical staff and equipment them with the appropriate patient lifting equipment to respond in place of WMAS. Initially the service was offered to those patients within care & residential homes but has now expanded out to the wider community. The service has shown encouraging data since its inauguration. The falls service continues to grow at pace with further engagement and awareness events planned for 2024. The service target is to reduce unnecessary falls conveyances into A&E whilst freeing up capacity for WMAS. To date in 9 full months and 1 week of April since offering the service we have seen a total 864 calls with an average 0f 87% of those patients being treated and remaining at home.

- Further development of **Virtual Wards**. On 23rd February 2024 Dudley Group NHS Foundation Trust, alongside partners, took place in a Get it Right First Time (GIRFT) review on their virtual ward programmes. This provided us with a set of recommendations on ensuring the virtual ward programme is both cost effective and meeting the needs of the population and system. Recommendations included:
    - Extension of virtual wards to include step up.
    - Aligned workforce modelling, electronic prescribing, shared care records.
    - Align all virtual wards to stop isolation and pool resources.
    - Ensure virtual wards are aligned/integrated with other services (i.e. social care).
    - Explore an integrated model to and from the virtual wards with community, primary and secondary care provision.
    - Increase use of technology.
    - Equal urgent access to diagnostics (same urgent access as inpatients).
    - Review access for all ethnicities: access does not match ICB ethnicity data.
    - Daily access to a consultant.
    - Review of patient cohort and discharging those without criteria to reside.
    - Ensure care home residents have equal access to virtual wards.

- There has been further development and investment into the **Short-Term Assessment and Reablement Service (STARS**). Investment from the ICB's System Development Fund in 2023-24 has created a more robust and mature service with a sustainable pathway 1 (domiciliary care at home) offer, creating a management structure which puts more resilience into this service. This funding is now included in our BCF plan. Moving forward there is still further work to do on how this service is dovetailed into the Own Bed Instead Service (OBI) and creating more capacity for pathway 1 to meet day to day demand.

  Pathway 1 is now more closely aligned with the community therapy teams, ensuring that therapy plans are timely and robust giving people the best possible opportunity to regain and retain a level of independence. Ward staff have also received training so that when completing the transfer of care

documents and making pathway recommendations, they are fully aware of options available and can ensure that 'Home First' is always considered.

- We have been more flexible around our bed offers, flexing the pathways when required to support hospital discharge. For example, when there are challenges with capacity in pathway 1 (domiciliary home care provision), people have been transferred to a pathway 2 bed-based service for a few days whilst waiting for the package of care to start. This has helped maintain flow at the back door of the hospital.

- There has been a discharge review process undertaken, reviewing areas such as the **Transfer of Care Hub and data platforms**. Over the summer of 2024 we will be considering the findings of this review, in conjunction with other work to develop an improvement programme. The full breakdown of recommendations made by the team are included as appendix 3. Overarching recommendations are:

    - Improvement of data/Information Technology.
    - Clear demand and capacity modelling with flexible use of pathways/funding.
    - Improved integration and communication.
    - Clearer/improved sharing of patient information.
    - Clear leadership roles/functions

- During 2023-24 we continued to embed the **Palliative Care Strategy** and its recommendations, alongside the development of a more integrated palliative care team. There has been a focus in 2023 around current EOL provision. Dudley was invited by the Black Country Integrated Care Board to undertake an audit which focused on 6 main areas of provision and then input alongside the other 3 localities (Walsall, Wolverhampton and Sandwell) into the "Black Country Palliative and End of Life Care Strategy 2023-26".

  A localised action plan was agreed with our EOL committees that targeted agreed areas of improvement that would ultimately underpin the strategy with governance through the ICB End of Life Oversight Committee for assurance. Dudley agreed an 8-point improvement plan which can be seen below. Each action has an owner and is monitored using a progress plan with agreed achievement dates, monitored via a RAG rating system. As the action plan is fluid, the actions are regularly reviewed with the ability to add new areas of work if required.

  Dudley is making good progress against the actions with 2 Key actions already completed and several underway bringing together information sources from multiple stakeholders. Action 7 is the only outstanding action where development of a care home training package requires new financing not currently available within the system.

  Once completed the group has agreed to refresh the plan ready for April 2025 to further support delivery of the Black Country Palliative and End of Life Care Strategy 2023-26.

| | | |
|---|---|---|
| 1 | Identify a substantive SRO to replace interim cover by Dec 2024 | **Complete** |
| 2 | Evaluate the current EOL skills training packages available within Dudley by July 2024 | **Ongoing** |
| 3 | Each organisation to provide baseline data for EOL by March 2024 | **Complete** |
| 4 | Complete a full Dudley EOL Service mapping and stakeholder exercise which includes CYP by Sept 2024 | **Ongoing** |
| 5 | Capture patient experience data on preferred place of care and analyse quantitative data around the use of ACP before Aug 2024. | **Ongoing** |
| 6 | Establish a suitable EOL patient forum or introduce patients into the local PEOLC meetings for care homes by Sept 2023 | **Complete** |
| 7 | Launch the 6 Step EOL Programme within Dudley Care Homes. Home - Six Steps (eolp.co.uk) by April 2024 | **Overdue** |
| 8 | Implement and Imbed Epaccs across Dudley before the end of the year 2025 | **Not Started** |

- Our **Community Partnership Teams** (CPTs) have continued to mature over 2023-24. Our CPTs are multidisciplinary meetings taking where complex patients are discussed with a variety of professionals to provide additional support and advice to help keep people independent and at home where possible. Progress over the last 6 months has seen:

    - Dedicated Leadership across all 6 Primary Care Networks (PCNs).
    - Improved compliance and attendance at CPT meetings.
    - Standardisation – roles and responsibilities, service model, agenda for team meetings.
    - Alignment of Intermediate Care Team to each CPT – to facilitate better discharge co-ordination.
    - Palliative Care focused CP's.
    - Complex Mental health CPTs – alignment of adult psychiatrists, older adults in progress.
    - Dedicated substance misuse CPT– bimonthly with links into individual CPTs from Atlantic House.
    - Diabetes Population Health management – PARM risk stratification tool, transition from individual GP practice model to CPT model which is being piloted November/December 2024.
    - Respiratory focussed CPT – alignment of Respiratory consultants/DRAS team, bespoke CPT pre-winter approach (October/December), step-up pathway for Virtual Wards.
    - Updated CPT referral form and EMIS template – to ensure systematic capture of data, will include specialist Long Term Condition Areas.
    - Development of CPT contact protocol – contact details of all staff (including ARRS staff aligned to each PCN).
    - CPT Communication tool – improves day to day communication between team and GP practices.

- Development of CPT metrics – hospital admissions and GP attendances.

- In our 2023-25 plan we referenced the Development of the Carers' Hub working with Dudley Group NHS Foundation Trust which was due to open in 2023. The HUB has now been renamed as the 'Information Hub', so it could incorporate information and advice for patients, carers, and staff. There has been a delay to this opening, but it is now in the final stages of construction. This should be open in May/June 2024 which will coincide with Carers Week.

- In 2023-24 we took advantage in a Better Care Team offer to work with the organisation Changeology. As part of this offer, they interviewed 14 people from all partners to understand how partners viewed capacity and demand management and perspectives on how we can continue to develop and transform our services. The report identified several themes:

  - The need for a shared vision.
  - Improved communication and organisational integration.
  - Improved discharge processes.
  - Capacity and demand planning to ensure visibility of system flow.
  - Data driven decision making.
  - Constraints of financial pressures.

  The team made 6 recommendations:

  - The System should undertake the formal establishment of the objectives and responsibilities of individual partners.
  - Opportunities exist to improve communication by utilising existing channels and relationships.
  - Focus on a review of the current state analysis of discharge pathways to formulate an initial understanding of how it is currently operating.
  - Improving the visibility of patient flow and enabling sophisticated capacity and demand planning.
  - Facilitate data informed decision making at all levels of the System.
  - Address financial challenges, include increasing transparency in cost sharing mechanisms, enhancing flexibility in funding arrangements, and fostering more efficient resource utilisation to mitigate the financial impact on the system. efficient resource utilisation to mitigate the financial impact on the System.
  - In 23/24 we conducted a Back to Basics review on our Better Care Fund Plan. This involved all partners working together to review the current plan, what is working well and identify opportunities for transformation work. The outcomes of this review 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.

- Reviewing the admission avoidance beds across health and social care to look at opportunities for joint commissioning and shared resource.
- Reviewing the social work element within the plan (Health and Social Care) to identify any areas of duplication which can be transformed into efficiencies.
- Review medical support into step down facilities.
- We reviewed the leadership of our BCF programme in Dudley. We did some caparison work with other local places and looked at outcomes and compared management structures. As a result of this work, we agreed across partners that a specific workforce for management of the BCF plan was not required and that this forms part of the teams existing job plan and that BCF management should be everyone's business. However, we agreed to develop a virtual PMO team, using existing workforce with a more streamlined process for management of the Better care Fund.

**BCF 24/25 Plan Review**

- In 2023-24 we conducted a Back to Basics review on our Better Care Fund Plan. This involved all partners working together to review the current plan, what is working well and identify opportunities for transformation work. The outcomes of this review 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.
    - Reviewing the admission avoidance beds across health and social care to look at opportunities for joint commissioning and shared resource.
    - Reviewing the social work element within the plan (Health and Social Care) to identify any areas of duplication which can be transformed into efficiencies.
    - Review medical support into step down facilities.

- We reviewed the leadership of our BCF programme in Dudley. We did some comparison work with other local places and looked at outcomes and compared management structures. As a result of this work, we agreed across partners that a specific workforce for management of the BCF plan was not required and that this forms part of the team's existing job plan and that BCF management should be everyone's business. However, we agreed to develop a virtual PMO team, using existing workforce with a more streamlined process for management of the BCF.

- The following changes have been made for the 2024-25 plan.

- Additional funding for a handyman scheme to support the existing scheme funded by DMBC. This funds more specialist home interventions to support discharge, such as specialist house cleans.
- Additional funding for ad hoc support to facilitate same day discharge.
- Further investment into mental health services including funding a dedicated mental health nurse to be part of the existing High Intensity Users Service (HIU) which supports people accessing services at Dudley Group NHS Foundation Trust on a frequent basis.
- Care home brokerage team, currently delivered by Dudley Integrated Health and Care NHS Trust has now been added to the plan for 2024-25. This service will transfer to Dudley Group NHS Foundation Trust on 1 July 2024.
- Additional investment to the Dudley Clinical Hub and Own Bed Instead (OBI) has now been added to the BCF plan for 2024-25.

**Priorities for 2024-25**

Following the review of work undertaken in 2023-24 and the recommendations made following reviews we have agreed our programmes of work for 2024-25

- To hold a workshop in June 2024 to consider the findings of the:
  - Discharge review
  - Virtual ward GIRFT
  - Changeology report
  - Back to Basics review
  - To develop a work programme from the workshop with clear timelines for implementation.

**Further Plans**

- Partners are working collaboratively to develop a trigger mechanism when there is an anticipated surge in referrals, this will allow each pathway to take additional measures in preparation to manage any potential surges in activity.
- Plans to increase capacity in Pathway 2 (bed-based rehabilitation) by decreasing length of stay. This includes the development of a patient information leaflet given to individuals on admission to a Pathway 2 bed. The letter describes that the individual will be given an Estimated Date of Discharge and may be transferred out of the facility once they are rehab complete. There are pathways in place to complete timely discharges through reablement from Pathway 2 beds in the community and close links with Own Bed Instead to ensure we can implement care quickly when there are care and support needs and not just therapy.
- Plans in place to improve the current weekly Situation Report (Sitrep), showing delays within Pathway 2. The Sitrep will be RAG rated with a set of actions to escalate delays to discharge, once the individual has reached their Estimated Date of Discharge.
- Demand modelling has shown, a reduction in patients requiring a residential bed-based rehab facility, the assumption is that this group of patients are being discharged to have therapy input within their own home. There have been multi-agency discussions in utilising this capacity, to enhance flow from

other nursing rehab units. This facility will also flex its current capacity to accommodate appropriate Pathway 3 and non-weight bearing patients and reduce spend on spot purchase. In periods of high escalation this facility will also accommodate Pathway 1 patients until their Package of Care (POC) is available.

- From June 2024 we are looking at using Assistive Technology to reduce the amount of care provided through formal carers, there is a criterion that we have implemented. This will support with prompts and reminders only through this technology, Supporting Independence through technology (SITT). This will be piloted initially through the reablement process to support admission avoidance in the community.
- We need to maximise our current capacity on Pathway 1. There are communications in place to ensure that we are maximising our discharges when there are some incomplete discharges that are out of our control, we monitor and replace care to ensure waiting lists are reduced and monitored throughout the day. Following the Walsall Peer review, it was identified that 6-7 discharges per day would be required to sustain flow, however the current capacity allows 5 per day (35 per week) We are flexible with our discharges to ensure that we remain within our available capacity but can reduce or increase our discharges dependent on demand and surges on certain days.

## Appendix 1: Better Care Fund Metrics

### Metric Definitions

Source : The Better Care Exchange

**Metric 1: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population. Collected Annually.**

**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.
**Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from the Short- and Long-Term Support (SALT) return, collected by NHS England. **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.

**Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. Collected Annually.**

The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for reablement or rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of in scope discharges. **Denominator:** Number of in scope discharges.

**Metric 3: Unplanned hospitalisation for chronic ambulatory care sensitive conditions. Collected Monthly by Central BCF Team, published on Better Care Exchange.**

This indicator measures the number of times people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital in an emergency. The **numerator** is given by the number of finished and unfinished ***admission episodes***, excluding transfers, for patients of all ages with an emergency method of admission and with a primary diagnosis of an ambulatory care sensitive condition such as: acute bronchitis, angina, ischaemic heart disease, heart failure, dementia, emphysema, epilepsy, hypertension, diabetes, COPD, pulmonary oedema. Because the **denominator** for the official published measure (***mid-year population estimates*** for England published by the Office for National Statistics (ONS) are only available in June following the end of year in question, baseline data provided in the BCF template uses mid-year estimates for 2020-21 as a denominator).

**Metric 4: Discharge to usual place of residence. Collected Monthly by Central BCF Team, published on Better Care Exchange.**

This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Maximising the proportion of people who return to their usual place of residence at the point of discharge enables more people to live independently at home. This indicator measures the percentage of discharges that are to a person's usual place of residence.
**Numerator:** The number of discharges of people over the age of 18, following an inpatient stay, that are recorded as being to a person's usual place of residence. **Denominator:** All completed hospital spells recorded in SUS for people over the age of 18 – calculation on monthly total. Does not include Same Day Emergency Care (Zero day) admissions.

**Metric 5: Metric 5: Reducing the number of emergency hospital admissions due to falls in people over 65**

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, This indicator is an important measure around joint working between adult social care and health partners (e.g. urgent community response services) to prevent hospital admissions and reduce falls which will improve outcomes for older people and support independence.
**Numerator:** Emergency admissions for falls injuries for people over the age of 65, classified by primary diagnosis code (ICD10 code S00 to T98) and external cause (ICD10 code W00 to W19) and an emergency admission code (episode order number equals 1, admission method starts with 2). **Denominator:** Local Authority level estimates of resident population aged 65 and over.

# Metrics 1 and 2 - Supporting the long terms needs of older people

Source : Local Authority Colleagues
Period : Q1 2022/23 : Q4 2022/23

Local Authority metrics are collected on a quarterly basis as the 91 day metric does not lend itself to monthly monitoring. These are local monitoring figures, the official metrics are collected annually.

| HWB Name | Period | 1a. Admissions to residential and care homes – 18-64 (per 100,000 pop) | 1b. Admissions to residential and care homes – 65+ (per 100,000 pop) | 2. Proportion of people aged 65+ discharged who are still at home after 91 days |
|---|---|---|---|---|
| Dudley | 2022/23 Q1 | 6.40 | 457 | 0.98 |
| Dudley | 2022/23 Q2 | 10.70 | 503 | 0.90 |
| Dudley | 2022/23 Q3 | 11.00 | 619 | 0.88 |
| Dudley | 2022/23 Q4 | 11.00 | 533 | 0.88 |

# Metric 3 Dudley Avoidable (Chronic Ambulatory Care Sensitive) Admissions

Source : Data Published on Better Care Exchange
Period : October 2022 : January 2024

The count of observed avoidable admissions has increased markedly from Q3 of 2022/23 and this increased level of activity is the new norm.

Using crude rates per 1,000 population to benchmark the ICB's four places, Dudley's has markedly worsened, although there has been some improvement in recent months. However, it should be noted that the average rate per 1,000 population has also increased elsewhere which would tend to suggest that the coding change is not the only reason for the Dudley increase.

The red lines on the chart are the upper and lower control limits, data points beyond these (marked as red) should be considered to be outside the "normal" range of variation.

**Average Rate in Reported Period**

| HWB Name | Ave Rate / 1,000 Pop |
|---|---|
| Dudley | 1.15 |
| Sandwell | 1.00 |
| Walsall | 1.24 |
| Wolverhampton | 1.14 |

**Average Rate in Last Three Months**

| HWB Name | Ave Rate / 1,000 Pop |
|---|---|
| Dudley | 1.18 |
| Sandwell | 1.05 |
| Walsall | 1.37 |
| Wolverhampton | 1.21 |

**Rate in Latest Reported Month**

| HWB Name | Rate / 1,000 Pop |
|---|---|
| Dudley | 1.25 |
| Sandwell | 1.04 |
| Walsall | 1.30 |
| Wolverhampton | 1.31 |

Observed Admissions

# Metric 4 Dudley Patients Discharged to Usual Residence (DTUR)

Source : Data Published on Better Care Exchange
Period : October 2022 : January 2024

The generally accepted ambition for the proportion of patients discharged to their usual residence is 95%, a figure that has not been achieved in Dudley in the monitored period. Only Walsall consistently averages 95%. Recent months have seen some improvement in this metric for Dudley Place.

The red lines on the chart are the upper and lower control limits, data points beyond these (marked as red) should be considered to be outside the "normal" range of variation.

**Average DTUR in Reported Period**

| HWB Name | Ave % DTUR |
|---|---|
| Dudley | 93.17% |
| Sandwell | 94.20% |
| Walsall | 95.57% |
| Wolverhampton | 93.20% |

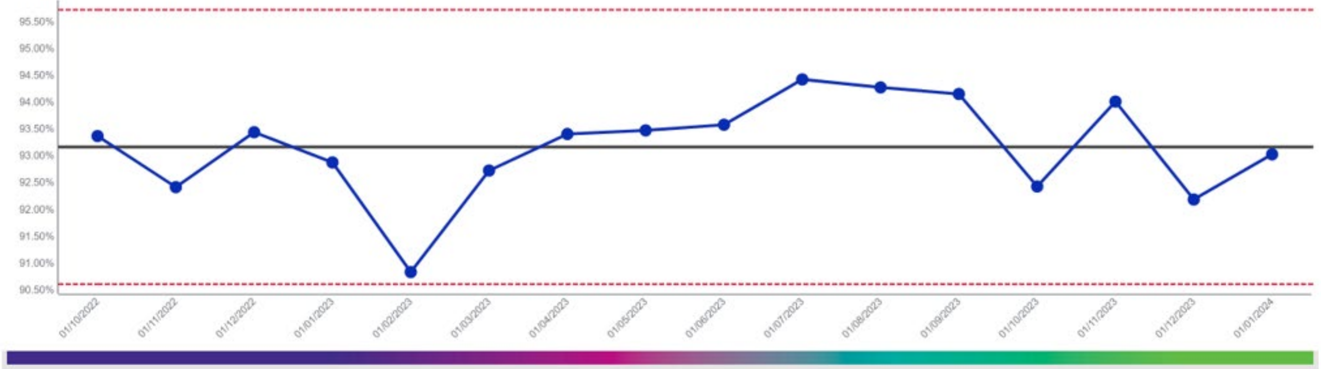
**Average DTUR in Last Three Months**

| HWB Name | Ave % DTUR |
|---|---|
| Dudley | 93.08% |
| Sandwell | 94.00% |
| Walsall | 95.61% |
| Wolverhampton | 93.53% |

**DTUR in Latest Reported Month**

| HWB Name | Ave % DTUR |
|---|---|
| Dudley | 93.03% |
| Sandwell | 94.22% |
| Walsall | 95.38% |
| Wolverhampton | 92.97% |

**Trend in the Proportion of Spells Discharged to Usual Residence**




# Metric 5 Dudley Patients Aged 65 and Over Admissions Coded to Falls

Source : Data Published on Better Care Exchange
Period : October 2022 : December 2023

The count of observed falls admissions increased markedly between October 2022 and January 2023 but has since fallen back to levels seen in earlier months. Nevertheless, falls admissions have been on an upwards trajectory from the start of the monitored period. The falls data is subject to considerable latency.

The increase between October 2022 and January 2023 was due to increased pressures during winter months. Admissions decreased substantially early 2023. It is worth noting that in terms of standardised rates, Dudley's performance is better than the ICB average.

The red lines on the chart are the upper and lower control limits, data points beyond these (marked as red) should be considered to be outside the "normal" range of variation.

**Average DSR in Reported Period**

| Organisation | Average |
|---|---|
| Dudley | 170.11 |
| Sandwell | 174.04 |
| Walsall | 213.88 |
| Wolverhampton | 253.95 |

| Organisation | Average |
|---|---|
| ICB | 199.02 |

**Average DSR in Last 3 Months**

| Organisation | Average |
|---|---|
| Dudley | 161.72 |
| Sandwell | 160.46 |
| Walsall | 192.54 |
| Wolverhampton | 255.62 |

| Organisation | Average |
|---|---|
| ICB | 188.30 |

**Average DSR in Latest Month**

| Organisation | Average |
|---|---|
| Dudley | 206.01 |
| Sandwell | 152.12 |
| Walsall | 210.85 |
| Wolverhampton | 245.81 |

| Organisation | Average |
|---|---|
| ICB | 202.91 |

**Observed Admissions**

**Appendix 2 System Performance**

The information below provides an insight into the activity in the Dudley urgent and emergency care system.

Figure1 ED Total Performance

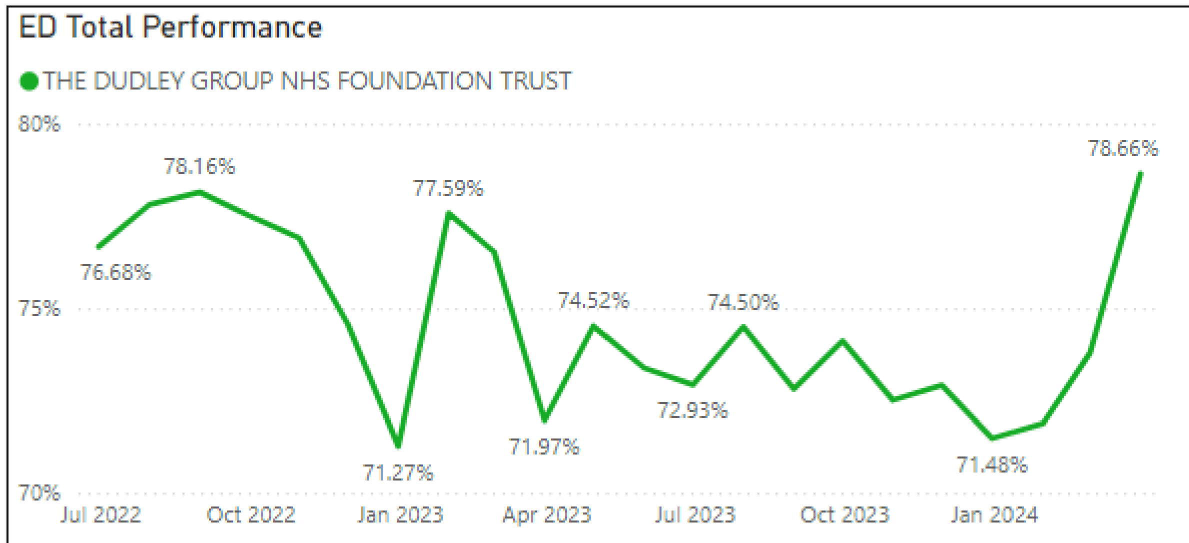
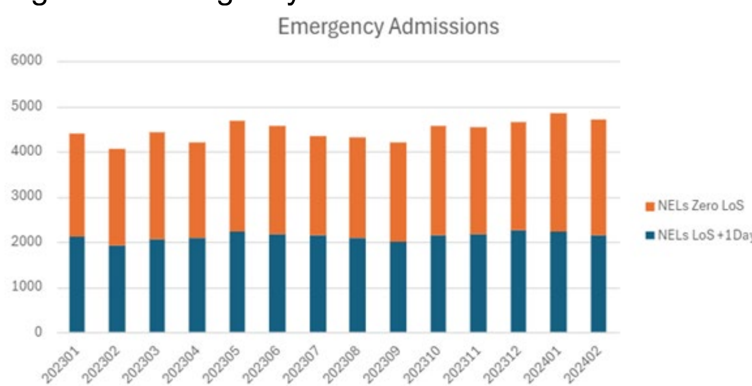



Figure 1 shows that during the last 12months there has been a general reduction in the performance of ED in Dudley. Performance measures the amount of time people spend in the department from arrival to admission/discharge. During the February period the performance has improved. This could in part be due to improved collaboration between our ED department and our Urgent Treatment Centre which is co-located and therefore these figures are combined. figures. The national target is for patients to be seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.

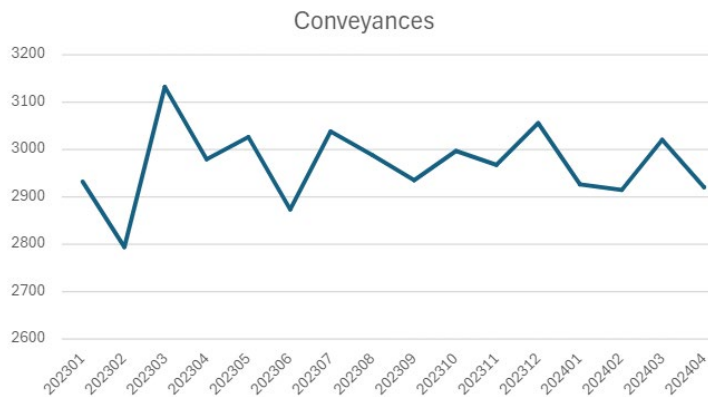
Figure 2: Emergency admissions




Emergency admissions have remained static throughout the last 12 months. However, partners anecdotally say that the acuity and complexity of

admissions has increased significantly, meaning that their length of stay increases and ability to discharge is more difficult.

Figure 3 Conveyances to DGFT




This shows that ambulance conveyances to DGFT have remained relatively static, with some peaks, although the general theme is that conveyances sit at between 2900 and 3000 per month, just under 100 conveyances per day. Further work is required to use alternative pathways, including the Clinical Hub, to avoid people being conveyed to hospital inappropriately.

Figure 4: Care Home admissions:

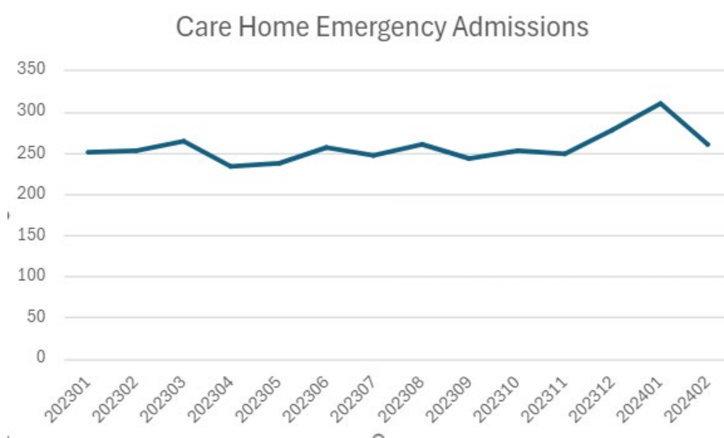



Figure 4 shows that as expected a spike is recorded for December 2023 for residents of care homes admitted to hospital, admissions reduced in January/February 2024, however the number of admissions remains the same as the same period last year. Ongoing work with care homes is provided by the Care Home Education Team (CHET) which includes 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. Calls to our clinical hub from care homes have increased over the same period which is good news.

Figure 5: UCR referrals

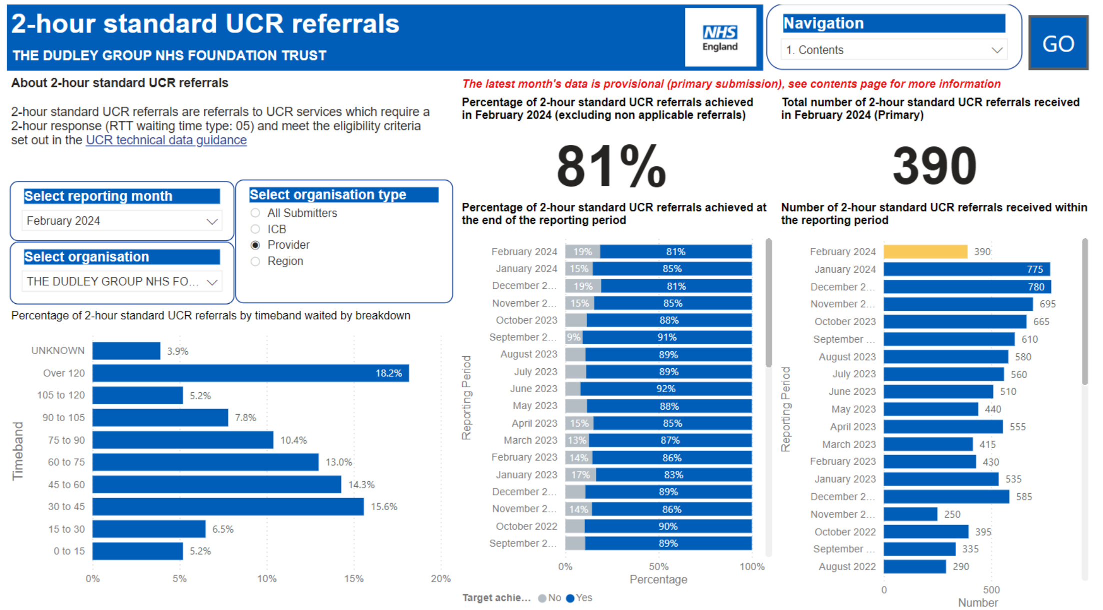



Figure 6: Falls Response

| | 2023-04 | 2023-05 | 2023-06 | 2023-07 | 2023-08 | 2023-09 | 2023-10 | 2023-11 | 2023-12 | 2024-01 |
|---|---|---|---|---|---|---|---|---|---|---|
| Total Falls Calls | 25 | 50 | 87 | 84 | 62 | 95 | 106 | 95 | 125 | 135 |
| % of patients that remained at home | 100% | 85% | 85% | 84% | 92% | 96% | 85% | 84% | 88% | 91% |

Figure 6 shows that the referrals to the fall's response have been slowly increasing which is positive news.

Figure 7: Dudley Intermediate Care metrics

## Dudley Intermediate Care Metrics

Source : Intermediate Care Service
Period : April 2023 : March 2024

NHS Black Country Integrated Care Board Business Intelligence Team

**Average Length of Stay (LOS) by Month**

| Month | 2023 April | 2023 May | 2023 June | 2023 July | 2023 August | 2023 Septe... | 2023 Octo... | 2023 Nove... | 2023 Dece... | 2024 January | 2024 Febru... | 2024 March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Average LOS | 44 | 46 | 46 | 47 | 45 | 46 | 44 | 46 | 47 | 49 | 47 | 46 |

**Block Bed Occupancy by Month**

| Month | 2023 April | 2023 May | 2023 June | 2023 July | 2023 August | 2023 Septe... | 2023 Octo... | 2023 Nove... | 2023 Dece... | 2024 Janua... | 2024 Febru... | 2024 March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Block Occupancy | 89.00% | 91.00% | 90.00% | 92.00% | 90.00% | 91.00% | 89.00% | 89.00% | 93.00% | 96.00% | 95.00% | 94.00% |

**SPOT Beds Commissioned by Month**

SPOT Beds ● SPOT Neuro-Rehab

| Month | 2023 April | 2023 May | 2023 June | 2023 July | 2023 August | 2023 Septe... | 2023 Octo... | 2023 Nove... | 2023 Dece... | 2024 January | 2024 Febru... | 2024 March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Beds | | | | | | | | 7 | 8 | 11 | 11 | 13 |

***Commentary***

**Average Length of Stay** - the ambition is to achieve an average LOS of 28 to 42 days (Intermediate Care Framework). Multiple projects have been established to reduce average LOS in Dudley.

**Block Bed Occupancy** - the current model allows flexibility within pathways and prevents unnecessary hospital admissions.

**SPOT Beds Commissioned** - no SPOT purchased capacity has been required; patient flow has been managed through the substantive bed stock.

**SPOT Neuro-Rehab Beds Commissioned** - SPOT purchased Neuro-Rehab capacity is required when West Park is unable to accommodate a patient.

Figure 7 shows that the length of stay in pathway 2 has remained about the same over the last 12 months. As the narrative explains, the aim is to reduce the length of stay in these beds to create additional capacity.

Figure 8: Dudley Clinical Hub triage: phone referrals

## Dudley Clinical Hub Triage - Telephone Referrals

Source : Dudley Clinical Hub
Period : January 2023 : March 2024

NHS Black Country Integrated Care Board Business Intelligence Team

**Total Telephone Referrals**

**Telephone Referrals by Source**

| Referral Source | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [A] GP REFERRALS | 648 | 554 | 616 | 443 | 574 | 668 | 564 | 569 | 567 | 624 | 588 | 493 | 615 | 642 | 576 |
| [B] WMAS REFERRALS | 229 | 187 | 210 | 207 | 196 | 203 | 230 | 227 | 148 | 204 | 186 | 267 | 264 | 235 | 175 |
| [C] 111 | 22 | 32 | 40 | 30 | 18 | 12 | 11 | 26 | 24 | 22 | 17 | 24 | 25 | 17 | 28 |
| [D] CARE HOME REFERRALS | 552 | 459 | 476 | 539 | 560 | 509 | 535 | 545 | 640 | 695 | 709 | 781 | 811 | 618 | 717 |
| [E] OTHER | 342 | 293 | 280 | 197 | 335 | 448 | 468 | 395 | 504 | 569 | 524 | 502 | 524 | 494 | 539 |
| **Total** | **1793** | **1525** | **1622** | **1416** | **1683** | **1840** | **1808** | **1762** | **1883** | **2114** | **2024** | **2067** | **2239** | **2006** | **2035** |

**Telephone Referrals by Source %**

| Referral Source | Jan 23 | Feb 23 | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [A] GP REFERRALS | 36.14% | 36.33% | 37.98% | 31.29% | 34.11% | 36.30% | 31.19% | 32.29% | 30.11% | 29.52% | 29.05% | 23.85% | 27.47% | 32.00% | 0 |
| [B] WMAS REFERRALS | 12.77% | 12.26% | 12.95% | 14.62% | 11.65% | 11.03% | 12.72% | 12.88% | 7.86% | 9.65% | 9.19% | 12.92% | 11.79% | 11.71% | 0 |
| [C] 111 | 1.23% | 2.10% | 2.47% | 2.12% | 1.07% | 0.65% | 0.61% | 1.48% | 1.27% | 1.04% | 0.84% | 1.16% | 1.12% | 0.85% | 0 |
| [D] CARE HOME REFERRALS | 30.79% | 30.10% | 29.35% | 38.06% | 33.27% | 27.66% | 29.59% | 30.93% | 33.99% | 32.88% | 35.03% | 37.78% | 36.22% | 30.81% | 0 |
| [E] OTHER | 19.07% | 19.21% | 17.26% | 13.91% | 19.90% | 24.35% | 25.88% | 22.42% | 26.77% | 26.92% | 25.89% | 24.29% | 23.40% | 24.63% | 0 |
| **Total** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **100.00%** | **0** |

Figure 9: Outcome to UCR referrals

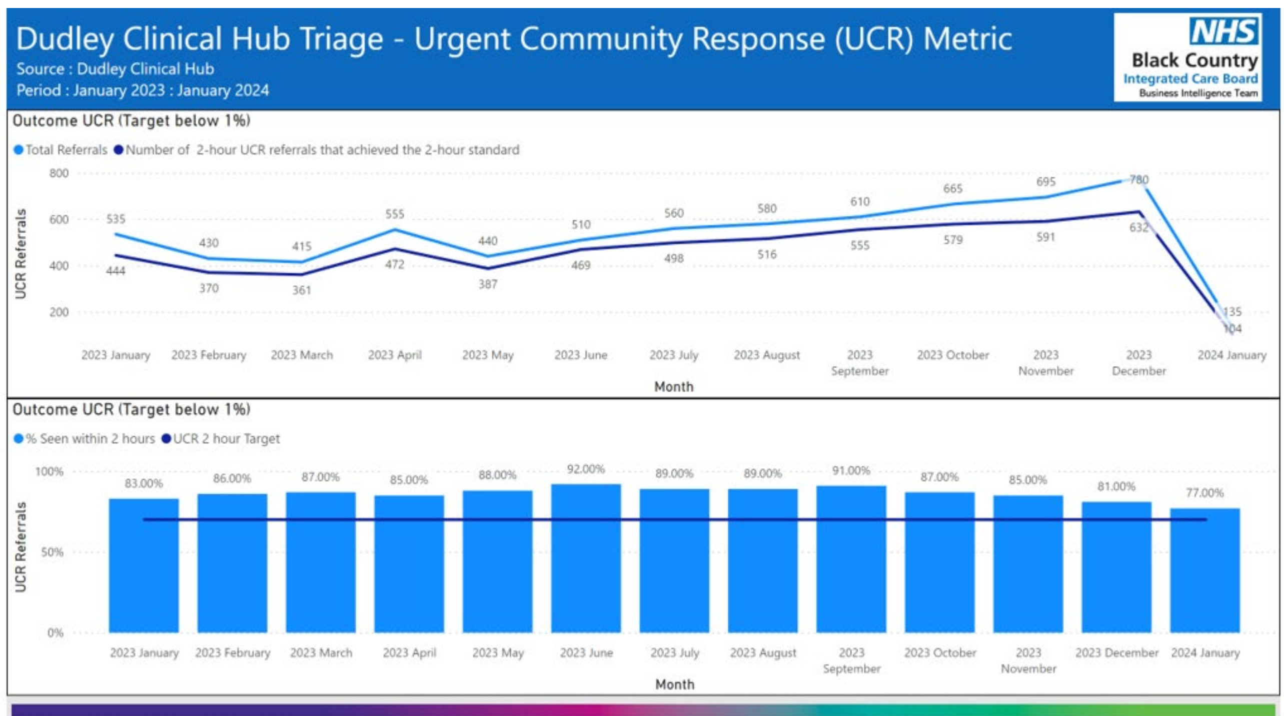



Figure 10: Falls response outcomes

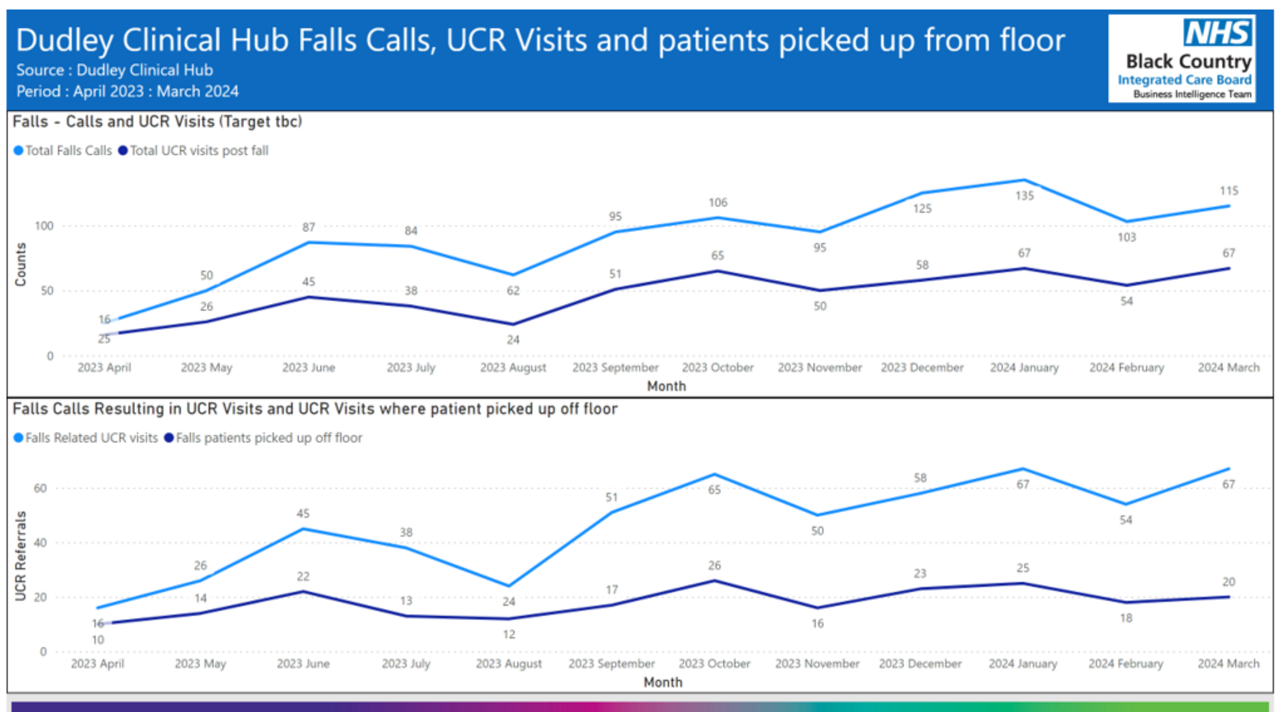
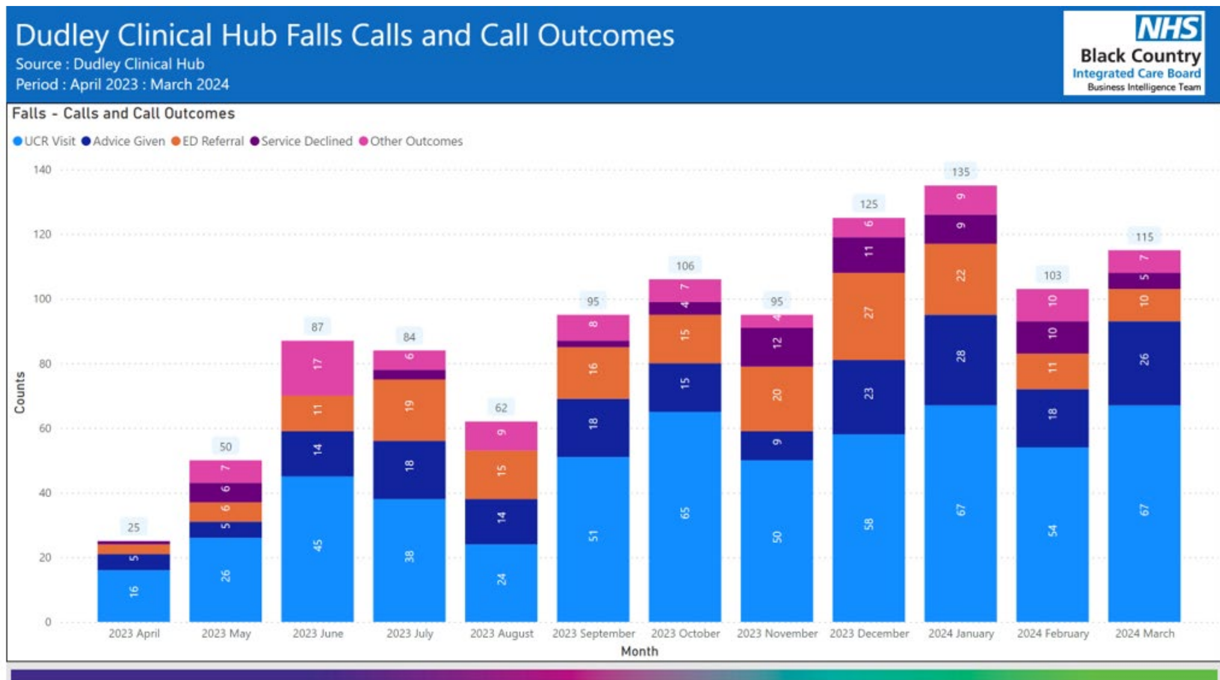


Figure 11: Hub calls and call outcomes



Appendix 3: Feedback from Discharge Improvement week

| Observation Log - Russells Hall Improvement Week | | | | |
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| Theme | | Observation | Impact | Recommendations |
| **Data / Information Technology** | **Areas of Good Practice** | Sunrise system is used across the organisation well which supports sharing of information and timely updates | System is used consistently well which improves communication and patient safety across teams. | Continue to strengthen the use of this system. Consider audits to review accuracy of information. |
| | **Areas for Consideration for Improvement** | Discharge Team cannot amend Sunrise system to change medically optimised status | Leads to inaccurate information and patients who are not medically optimised being counted in the daily figures. Team are also reviewing in excess of 150 patients a day and a large proportion are not medically optimised and this impacts capacity withing the team. | Allow members of discharge team to be able to change medically optimised status on sunrise to produce accurate data and release capacity spent on data cleansing. |
| | | Discharge Team do not have access or view of Dudley Adult Social Care system | Team is reliant on calling colleagues to obtain information. Risk that key information could be missed and patient safety compromised. | Consider the discharge team having access to Dudley Local Authority care system to enable data sharing. |
| | | Over reporting of Medically Optimised for Discharge patients on a daily basis. | Leads to inaccurate position and not one version of the truth for Trust and partners to monitor and make | Remove delays associated to not medically optimised, Pathway 0 and those referred to Discharge team that day to give an accurate position of delays, workload, and demand. |

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| | | | improvements against. | |
| | | Operational staff completing the data information for the medically optimised list, and this is time consuming. | Reduces operationally capacity of discharge team to work on discharges when they are data cleansing and updating the list. | Review of administrative support and their role in updating the medically optimised list and data cleansing. |
| | | Estimated Discharge Date (EDD) not consistently recorded or used across ward areas. | Makes early discharge planning difficult and is not aligned to national no criteria to reside guidance. | Implement EDD completion on sunrise system. |
| **Capacity** | **Areas of Good Practice** | Discharge Team managing high volumes of work on daily basis. | Daily TOC review in place and allocated effectively. Thursday the team completed 40 TOCs in a day. | TOC completion is tracked weekly by discharge team. Recommend reporting this regularly in format. |
| | **Areas for Consideration for Improvement** | Pathway 1 capacity not sufficient to meet demand | Initial reviews indicate between 60-70 P1 care packages required weekly to meet demand. These patients are remaining in hospital and not being discharged timely. | Review of Pathway 1 length of stay to understand if blockages on exit from this pathway. Better Care Fund / Hospital Discharge budget to be reviewed for 2024/25 to explore building in additional capacity. |
| | | Pathway 3 capacity not sufficient to meet demand | Initial reviews indicate between 10-15 beds required weekly for P3 to meet demand. These patients are remaining in hospital and not being | Review of Pathway 3 length of stay to understand flow from P3. Better Care Fund / Hospital Discharge budget to be reviewed for 2024/25 to explore building in additional capacity. |

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| | | | discharged timely. | |
| | | No contingency if Pathway 2 or Pathway 3 homes closes due to infection control precautions. | Further impact on patient flow. | Consider the risk and having emergency funds to support additional capacity if this happens to ensure patient flow is not impacted. |
| | | Pathway 2 capacity is significant and likely holding Pathway 1 patients. | The true demand for Pathway 1 is masked by use of Pathway 2 beds. | Home First model needs exploring and consideration of use of Wrap around care packages to reduce P2 usage. Review of Pathway 2 length of stay and flow would be beneficial. |
| | | Bed state not always clear on a daily basis in Pathway 2 and 3 beds and the upcoming bed availability. | Planning is difficult without clear P2 and P3 bed state. | Review of P2 and P3 length of stay to understand flow.<br>Consider a daily P2 and P3 bed state to be shared with discharge team and partners including discharges planned for next 7 days. |
| | | Flexible use of Pathway 2 beds is not consistent, and query is there an agreed process for this. | Pathway 2 used flexibly to support flow from acute but not on a daily basis. Indicates that P2 capacity is higher than demand. | Review utilising P2 capacity on a daily basis to step patients down with confirmed discharge plans or confirmed discharge dates. To ensure empty beds are not left empty in community on any day. |
| | | Pathway 2 criteria appears to be restrictive as all patients on amber observations are declined. There are block P2 beds in EMI nursing and Dementia nursing homes which could potentially meet this need. Decision should be therapy to therapy. | Impact on equality of service access for patients having amber observations and access to bed-based rehabilitation. | Consider a review of criteria and therapy decision making within P2 beds. |

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| | | No Pathway 2 social care step down beds for house cleans, complex safeguarding or homeless patients. | Impact is that patients remain in acute beds for house cleans, housing referrals and complex safeguarding issues. | Consider funding P2 social care beds (suggest 4-5 beds) to enable step down from acute to address social delays. |
| | | Current capacity across pathways is not managing daily workload. P1 and P3 discharges not same day. | Impacts patient flow, patient experience and risk of functional decline and nosocomial infections. | Recommend not to delay capacity to end of week and work on today's requirements to enable a clearer understanding of capacity vs demand. |
| | | No social care triage at weekends for Pathway 1. | Team will only look at re-starts. This subsequently results in a surge of referrals on Monday morning. | Review social care weekend process to align to a 7-day discharge planning service. |
| | | Due to limited capacity and current capacity not meeting demand there is no capacity for surge planning ahead of known busy periods such as bank holidays or when Trust is on Level 4 escalation. | Impacts patient flow at times of increased pressure. Patient experience poor and increased risk of functional decline and nosocomial infections. | Consider funding capacity to support with surge in demand.<br>Consider a review of all Pathways 1,2 &3 and merging budgets of pathways to allow flexibility with capacity.<br>Single lead to manage Pathway 1.2&3 and discharge team processes and budgets across Dudley place. |
| | | All Pathway 2 and Pathway 3 are block purchased (except for a small number of spot). | This reduces flexibility in system and impact patient flow. | As part of a review of Pathways 2 and 3 consider reducing block provision and build in more spot provision. |
| **Integration** | **Areas of Good Practice** | RAG call takes place consistently and partners are engaged. | Ensures partners are aware of delays and delays agreed collectively and actions for day allocated to teams. | Continue with this process and use the afternoon call to discuss complex cases. A consistent P2 and P3 bed state would support this process. |

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| | | Relationships at Operational level between discharge team, local authority and DICH are good. | Daily calls, sharing of RAG list and agreeing responsibilities for delays is embedded. | Consider integrating the teams to further develop collaborative working. |
| | **Areas for Consideration for Improvement** | Integration between Local Authority and DICH and Discharge Team not embedded. Teams still work in silo and not co-located at any point. | The multi-agency working is limited by teams calls and can slow discharge planning down, particularly complex cases. | Consider a duty worker from local authority P1 and DICH P2 and P3 to be based with the discharge team daily to support the Multi-disciplinary and Multi-agency worker and strengthen integration. |
| | | Health and Social care budgets are managed in isolation and capacity does not meet demand. | No flexibility within discharge pathways and impacts patient flow and associated patient experience risks. | Consider merging budgets of pathways to allow flexibility with capacity. Single lead to manage Pathway 1.2&3 and discharge team processes and budgets across Dudley place. |
| | | Staff leave their camera's off on RAG calls except the Discharge Team Leader. | Lack of cameras on meetings can hinder communication and engagement and team building. | Consider embedding some standard meeting etiquette on teams calls to improve team building and integration. |
| **Patient Safety** | **Areas of Good Practice** | Regular run through of patients throughout day by discharge team. Team are aware of all medically optimised patients and consistently review to expedite discharges. | Discharge team engage well as a team and are led well to ensure discharges are safe. | Consider the discharge team having access to Dudley Local Authority care system to enable data sharing and improve patient safety. |
| | **Areas for Consideration for Improvement** | There are risks for patients with open safeguardings, as discharge team cannot see the local | There is a real risk that a safeguarding concern could be missed and put a patient at risk of potential harm. | Consider the discharge team having access to Dudley Local Authority care system to enable data sharing and improve patient safety. |

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| | | authority system. | | |
| | | Due to the limited capacity in Pathway 1 and Pathway 3 there is a risk of functional decline and nosocomial infections to inpatients waiting to be discharged. | Patient safety and patient experience impact. | Review of capacity and demand for all pathways recommended as well as a length of stay review. Consideration of pooled budgets across health and social care pathways with a single service lead post. |
| **Communication** | **Areas of Good Practice** | Good communication with discharge team and internal teams such as ward matrons. | Ensures internal delays and failed discharges are actioned and ownership taken. | Consideration needed for the feedback loop later in the day to ensure the actions are reflected on the medically optimised list produced by the discharge team as updates not always sent back from internal teams to discharge team. |
| | | Good daily communication with partners on RAG calls daily. | Aids flow of the day and identifies actions required. | Consider cameras to be on to further aid communication and team building.<br>Consider duty roles from local authority and DICH to be based on site with discharge team to aid communication channels. |
| | **Areas for Consideration for Improvement** | Escalation process is not always clear. | Some escalation completed by discharge lead but need a clear process and a senior escalation process to reduce delays. | Recommend to develop an escalation process to support discharge team within area and out of area escalations on a daily basis and when on high incident levels. |
| | | Therapy communication with team is not consistent and not always on the internal calls. | Can cause delays in discharge planning and incorrect information on medically optimised list. | Develop a process for internal communication and when information will be communicated back to discharge team. Would be beneficial to have a therapist based with discharge team to support quick wins etc. |
| **Leadership** | **Areas of Good Practice** | Operational Leader (KJ) is well-respected by her team and leads well. She has excellent knowledge of pathways and health and | Team are functioning well and clear large volumes of work daily and don't accept delays. | Team are held back by capacity issues in pathways, no clear escalation process and requires improvement in integration from partners (i.e. duty social worker on site etc). |

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| | | social care processes. | | |
| | Areas for Consideration for Improvement | Leadership duties across the team needs sharing with other discharge team managers to ensure all are working at same level and aligned. | It appears one manager is leading the team and if that person was to leave there is a real risk to the operational delivery of the service. | Consider a team of three leadership model with the three leaders at 8a and above level (including the therapy 8a). |
| | | Leadership at senior level appears disjointed with the separate budgets not supporting and integrated approach to discharge from acute and Pathway 1,2 and 3 management. | Impacts on patient flow and no cleat escalation process. | The weekly Tuesday meeting system call with senior leadership needs more structure around actions that can be taken to support flow and capacity. |
| **Additional / Misc.** | **Areas of Good Practice** | Food bank and clothes bank on site. | This supports timely discharge and solves problems. | Some areas have a small credit card for discharge teams to purchase small items for home or put gas and electric on etc. To consider this. |
| | | Discharge team have implemented weekly training sessions for internal wards on discharge planning and processes. | Will support sharing of information and communication between internal wards and discharge team. | Recommendation to continue with this practice and extend out to inductions of new staff including medics. |
| | **Areas for Consideration for Improvement** | Funding to support house cleans Discharge team are going out to house to arrange house cleans. ICB fund if patient can't. | This can cause delays in obtaining funding. | Budget to be given to discharge team to sign off house cleans up to a certain level to ensure no delays with discharge planning. |