Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

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

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

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

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

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG 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.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- 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:	Haringey
Completed by:	Paul Allen
E-mail:	paul.allen14@nhs.net
Contact number:	07742 605254

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

Job Title:	Director of Adults and Health, London Borough of Haringey
Name:	Beverley Tarka

Has this plan been signed off by the HWB at the time of submission?	No	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 25/11/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Lucia	Das Neves	lucia.dasneves@haringey.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Frances	O'Callaghan	frances.o'callaghan@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Rachel	Lissaeur	r.lissauer2@nhs.net
	Local Authority Chief Executive		Zina	Etheridge	Zina.Etheridge@haringey.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Beverley	Tarka	Beverley.Tarka@haringey.gov.uk
	Better Care Fund Lead Official		Paul	Allen	paul.allen14@nhs.net
	LA Section 151 Officer		John	Warlow	john.warlow@nhs.net
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Haringey

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,678,851	£2,678,851	£0
Minimum CCG Contribution	£21,020,860	£21,020,860	£0
iBCF	£9,518,076	£9,518,076	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£33,217,787**	**£33,217,787**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£5,973,533
Planned spend	£13,929,577

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,904,545
Planned spend	£6,904,546

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£1,067,000	(3.2%)
Community Based Schemes	£278,801	(0.8%)
DFG Related Schemes	£2,678,851	(8.1%)
Enablers for Integration	£1,617,202	(4.9%)
High Impact Change Model for Managing Transfer of (	£346,093	(1.0%)
Home Care or Domiciliary Care	£7,561,793	(22.8%)
Housing Related Schemes	£160,866	(0.5%)
Integrated Care Planning and Navigation	£8,857,376	(26.7%)
Bed based intermediate Care Services	£1,304,562	(3.9%)
Reablement in a persons own home	£7,047,078	(21.2%)
Personalised Budgeting and Commissioning	£475,000	(1.4%)
Personalised Care at Home	£1,469,029	(4.4%)
Prevention / Early Intervention	£354,136	(1.1%)
Residential Placements	£0	(0.0%)
Other	£0	(0.0%)
Total	**£33,217,787**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	593.0	666.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	11.5%	11.1%
	LOS 21+	5.8%	5.5%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	92.0%

Residential Admissions

		20-21 Actual	21-22 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	360	385

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Haringey

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Haringey	£2,678,851
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,678,851**

iBCF Contribution	Contribution
Haringey	£9,518,076
Total iBCF Contribution	**£9,518,076**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

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

CCG Minimum Contribution	Contribution
NHS Haringey CCG	£21,020,860
Total Minimum CCG Contribution	**£21,020,860**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£21,020,860**	

	2021-22
Total BCF Pooled Budget	**£33,217,787**

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

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Haringey

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,678,851	£2,678,851	£0
Minimum CCG Contribution	£21,020,860	£21,020,860	£0
iBCF	£9,518,076	£9,518,076	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£33,217,787**	**£33,217,787**	**£0**

Required Spend

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

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£5,973,533	£13,929,577	£0
Adult Social Care services spend from the minimum CCG allocations	£6,904,545	£6,904,546	£0

Checklist

Column complete:

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

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Health-orientated information, advice and guidance as part of wider advice model for citizens in Healthy Neighbourhoods	Voluntary sector provision of advice, information, signposting and/or guidance for people needing help	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£55,000	Existing
2	COPD Exercise Programme	Community-based exercise groups for suitable COPD patients referred via health professionals	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£13,000	Existing
3	Dementia Day Opportunities	LBH commissioned services to support people with dementia with facility- or wider home/ community-based day care/support. Other Providers - NHS Mental Health Provider, Charity / Voluntry Sector	Personalised Budgeting and Commissioning			Social Care		LA			Local Authority	Minimum CCG Contribution	£475,000	Existing

4	Self-Management Support	Structured programme of courses for patients interested in condition self-management or being expert patient	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£91,600	Existing
5	Local Area Coordination element of locality working and Healthy Neighbourhoods initiative	Voluntary sector coordinators to provide advice, information and signposting for people who need assistance and to support best use of community assets	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£120,136	Existing
6	Disabled facilities grant	LBH commissioned provider undertaking major adaptations of individuals' home to facilitate improvements in daily living functioning	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Private Sector	DFG	£2,678,851	Existing
7	Nursing services, including community matrons for MACC Team	District nursing for non-ambulant patients at home and community matrons to support anticipatory care (MACC Team)	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£7,070,798	Existing
8	Whittington Integrated Therapies and Therapeutic Support for Urgent Care Response	Multi-disciplinary therapy to support patients, including intermediate care/reablement solutions	Reablement in a persons own home	Other	Therapeutic comn	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,268,293	Existing
9	Integrated Health, Housing, Finance and Care Early Intervention In Hospital as part of 'Healthy Neighbourhoods in Acute'	Solutions to provide early help to people to help manage finances, housing health, well-being & independence via integrating community-facing Connected Communities into acute hospital	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£159,000	Existing

10	Integrated Health, Housing, Finance and Care Early Intervention Solutions to support Health Neighbourhoods in our Localities	Solutions to provide early help to people to help manage finances, housing, health, well-being & independence via integrating community-facing VCS solutions in HN collaboration	Community Based Schemes	Integrated neighbourhood services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£128,801	Existing
11	Multi-Agency Care & Coordination Team (GP Federation Commissioned Element)	MACC Team is GP-led multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£397,000	Existing
12	Multi-Agency Care & Coordination Team (Additional Nursing & Therapies Element)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity.	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£341,348	Existing
13	Multi-Agency Care & Coordination Team (Mental Health Element)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£89,000	Existing
14	Multi-Agency Care & Coordination Team (Social Care Element)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Social Care		CCG			Local Authority	Minimum CCG Contribution	£146,198	Existing
15	Multi-Agency Care & Coordination Team (MDT Teleconference including primary care)	MACC Team multi-disciplinary team works in anticipatory care team working to screen, triage, assess & delivery solutions to people with frailty/ multi-morbidity	Integrated Care Planning and Navigation	Other	Integrated approach - undertakes all of functions listed	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£253,447	Existing
16	Social Care Team	LBH posts to increase capacity in community first response, initial triaging & management of cases to support timely response	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£230,000	Existing

17	Social worker capacity for complex cases	Enhanced social worker capacity to better assess and manage more complex cases including those eligible for CHC	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£52,000	Existing
18	Strength and Balance Opportunities	Strengthening & balancing classes and exercises for individuals who professionals identify at risk of falling	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£58,000	Existing
19	Enhanced Health in Care Homes & Trusted Assessor	EHCH Model and Trusted Assessor across Haringey to support care homes, their staff & residents	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£216,000	Existing
20	IBCF Supporting Social Care	Bulk of spend on providing packages of care (predominantly but not exclusively domiciliary care) as part of social care clients' Personal Budgets	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£7,114,393	Existing
21	Palliative Care & Advanced Care Planning Facilitator	NMUH-led multi-agency approach to support range of community-, hospital- & bed-based palliative care services. Other Providers - NHS Community Provider	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£766,000	Existing
22	Increased investment in End of Life Nursing Care and other EOL services	Additional costs of community-based EOL care services in hospice	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£154,429	Existing
23	Alcohol Liaison Services	Council commissioned Alcohol Liaison Nurses & Support Worker to support patients in hospital with alcohol-related issues & to coordinate support in community	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£61,585	Existing
24	Support for Dementia Friendly Haringey	Council funded Dementia Coordinator to take forward development of DFH	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£20,000	New
25	Support for Community Navigation / Social Prescribing	Council commissioned support for community navigation/social prescribing network & community of practice	Enablers for Integration	Community asset mapping		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£15,000	New

26	Increase Single Point of Access/IDT-support function to meet demand (ASC component)	Contribution to ASC component of IDT/associated discharge planning including extended working (7 day working)	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£266,093	Existing
28	MH Discharge Coordinator	Social worker in non-acute MH hospital to support discharge and onward planning for individuals with severe MH issues.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£40,000	Existing
29	Home from Hospital	Voluntary sector scheme to support hospital patients (who do not need public-sector intervention) return home and settled if they need it	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£150,000	Existing
30	Rapid Response Service (inc at NMUH) - Community Health Element	Multi-disciplinary nursing & therapies team to respond quickly when people are at crisis and/or need short-term rehabilitation either at home or in A&E.	Reablement in a persons own home	Other	Crisis management in <2 or <24 hours	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£339,000	Existing
31	Rapid Response Service - ASC Element	Funding for rapid access to packages of care to support individuals at home at crisis - part of RR model	Reablement in a persons own home	Other	Crisis management in <2 or <24 hours	Social Care		LA			Private Sector	Minimum CCG Contribution	£71,000	Existing
32	Enhanced Virtual Ward - GP Element	Access to 'virtual ward' to support admission avoidance & facilitate hospital discharge - funding to increase access to primary care	Personalised Care at Home	Physical health/wellbeing		Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£42,000	Existing
33	Reablement Solutions	LBH time-limited community-based enablement & therapist staff to facilitate improvements in peoples' ability with daily living tasks	Reablement in a persons own home	Reablement service accepting community and discharge referrals		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,274,785	Existing
34	MH D2A Reablement	LBH community-based reablement to facilitate non-acute discharge of MH patients with physical health needs to improve their recovery in daily living tasks	Reablement in a persons own home	Reablement to support discharge - step down (Discharge to Assess pathway 1)		Social Care		LA			Local Authority	Minimum CCG Contribution	£52,000	Existing

36	Short-term intensive packages of care to support people to return home from hospital	Funding for high-intensity packages of care available to facilitate 'Home First' patient discharge in response to demand, particularly to support 7-day discharges	Reablement in a persons own home	Reablement to support discharge - step down (Discharge to Assess pathway 1)		Social Care		LA			Private Sector	Minimum CCG Contribution	£42,000	Existing
37	Additional Long Term Packages of Care for Individuals	Social care packages of care to facilitate hospital discharge over winter	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£447,400	Existing
38	Step down flats	Investment in step down flats for hospital discharge patients needing reablement & cannot return home	Housing Related Schemes			Social Care		LA			Local Authority	iBCF	£160,866	Existing
39	Care Home Intermediate Care Beds (iBCF-funded)	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Private Sector	iBCF	£539,936	Existing
40	Care Home Intermediate Care Beds (Minimum CCG Contribution)	Intermediate care P2 beds at care home supported by MDT (see MDT line)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Continuing Care		LA			Private Sector	Minimum CCG Contribution	£155,000	Existing
41	Community-Based Nursing & Care Home Intermediate Care (Convalescence) Beds	Intermediate care P2 beds focussed on convalescence at care home supported by MDT (see MDT line)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		LA			Private Sector	Minimum CCG Contribution	£413,523	Existing
42	Enhanced MDT to support indivudals' recovery & move-on in (particularly care home) P2 beds - Community Health element	Multi-disciplinary team, including nursing, therapies and social workers, to work with EHCH CH/PCN & care homes to support patients to recover & move-on	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£103,876	Existing
43	Enhanced MDT to support indivudals' recovery & move-on in (particularly care home) P2 beds - LBH element	Multi-disciplinary team, including therapies and social workers, to work with EHCH CH/PCN & care homes to support patients to recover & move-on	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		CCG			Local Authority	Minimum CCG Contribution	£92,227	Existing
44	Supporting people with challenging housing needs to return home post-hospital discharge	LBH-commissioned Housing Liaison Worker & rapid deployment of housing-related services (e.g. blitz clean) to help timely discharge	High Impact Change Model for Managing Transfer of Care	Housing and related services		Social Care		LA			Local Authority	Minimum CCG Contribution	£40,000	New

45	Investment in MSK Community Health & Primary Care services	Community health & primary care investment in MSK therapy services to improve people's health status & function (outside of IC)	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£344,000	New
46	Carers' Support	Range of carers' solutions depending on intensity of need: identifying carers, undertaking assessment of needs and support through to carers' respite. Providers are Local Authority and Voluntary Sector	Carers Services	Other	Includes carers' advice, IAG, care planning, respite services & DPs	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,067,000	Existing
47	Principal Social Worker	To provide quality assurance and plan workforce development for social care	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	Minimum CCG Contribution	£60,000	Existing
48	Commissioning & Analytics Support	To provide multi-disciplinary and multi-agency commissioning support for BCF Plan Programme	Enablers for Integration	Joint commissioning infrastructure		Social Care		Joint	50.0%	50.0%	Local Authority	Minimum CCG Contribution	£286,721	Existing
49	IBCF Market Management	Staff and other resources to manage brokerage and quality assurance of providers & contract management resources	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	iBCF	£1,255,481	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration
2. System IT Interoperability
3. Programme management
4. Research and evaluation
5. Workforce development
6. Community asset mapping
7. New governance arrangements
8. Voluntary Sector Business Development
9. Employment services
10. Joint commissioning infrastructure
11. Integrated models of provision
12. Other

1. Early Discharge Planning
2. Monitoring and responding to system demand and capacity
3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge
4. Home First/Discharge to Assess - process support/core costs
5. Flexible working patterns (including 7 day working)
6. Trusted Assessment
7. Engagement and Choice
8. Improved discharge to Care Homes
9. Housing and related services
10. Red Bag scheme
11. Other

1. Domiciliary care packages
2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)
3. Domiciliary care workforce development
4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
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).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
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.
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.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
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.

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.
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.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Haringey

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	593.0	666.0	20/21 figure impacted by Wave 1 COVID E&D trends, likely to see increase in 21/22. Improvements in anticipatory care in community & care homes, enhanced Rapid Response & engagement with underserved groups, to impact in 21/22. Prevent-ative solutions will have longer-term impact	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	11.5%	11.1%	Increase in 21+ more complex cases in Q3 anticipated to be higher % due to of increased number of non-COVID patients with more complex health (& social) issues. At same time anticipate additional funding & resources available in winter (partly BCF funded) will promote timely discharge and onward recovery, particularly in Q4. We have aligned our ambitions for targets with similar ambition on SITREP-based target for 2 local Trusts	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	5.8%	5.5%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	Increased investment in OOH, inc. reablement & housing support, functions will improve ability to facilitate people to return home post-discharge in H1 2021/22 (see BCF Narrative). Our % discharged dipped in Spring 2020 post-wave, so 21/22 ambition to improve to pre-pandemic postiion in H2.	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
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	468	443	360	385	Targets set v. 19/20 level. Represents 8% improvement on 19/20 position, which we believe realistic given in-year position. Achieved by ensuring even more people are helped at home for longer via more acessing out-of-hospital recovery and anticipatory care solutions (see Narrative)
	Numerator	130	124	103	114	
	Denominator	27,767	27,993	28,618	29,613	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

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

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	73.9%	80.0%	Position reflects ambition to return to pre-COVID levels and is supported through increased investment in reablement partly funded via BCF Plan in 2021/22, and closer alignment of Cmmunity Health & ASC services. Further details of our approach can be found in BCF Plan Narrative.
	Numerator	80	105	160	
	Denominator	100	142	200	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Haringey

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Ageing Well Strategy 2019-2023: https://www.minutes.haringey.gov.uk/documents/s111867/Ageing%20Well%20Strategy%20FULL%20V3.3.pdf Minutes of multi-agency Ageing Well Board Oct-21		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	Inequalities Fund - Healthy Neighbourhoods Proposal EQIA on AW Strategy Living Through Lockdown Report, Haringey Healthwatch: https://www.healthwatchharingey.org.uk/report/2020-08-19/living-through-lockdown		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Narrative Plan		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	Discussed at NMUH and WHT A&E Boards in Nov-21		