# 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.

**9. Source of Funding:**

- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority

- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

**10. Expenditure (£)2024-25:**

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

**11. New/Existing Scheme**

- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

**12. Percentage of overall spend.**

This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This was a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

**7. Metrics**

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2024-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2024-25.

Some changes have been made to the metrics since 2023-25 planning; further detail about this is available in the Addendum to the BCF Policy Framework and Planning Requirements 2023-25. The avoidable admissions, discharge to usual place of residence and falls metrics remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics.

The effectiveness of reablement metric will no longer be included in the BCF as there is no direct replacement for the previous measure.

The metric for rate of admissions to Areas should set their ambitions for these metrics based on previous SALT data.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:

- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

**1. Unplanned admissions for chronic ambulatory care sensitive conditions:**

- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2024-25. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2023-24 are pre-populated in the template and will display once the local authority has been selected in the dropdown box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:

https://future.nhs.uk/bettercareexchange/view?objectId=143133861

- Technical definitions for the guidance can be found here:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

**2. Falls**

- This metric for the BCF requires areas to agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter the indicator value as well as the expected count of admissions and population for 2023-24 and 2024-25 plan.
- We have pre-populated the previously entered planned figures for your information and further more recent data will be available on the BCX in the data pack here: https://future.nhs.uk/bettercareexchange/view?objectID=116035109

Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

**3. Discharge to usual 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. Areas should agree ambitions for a rate for each quarter of the year.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet where available else we will use the previously entered plan data.

**4. Residential Admissions:**

- This section requires inputting the expected and plan numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2023-24. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Although this data collection will be discontinued it is anticipated this will map across to the new CLD extract once this becomes available.

# 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.

| | | | Complete: |
|---|---|---|---|
| Health and Wellbeing Board: | North Yorkshire | | Yes |
| Completed by: | Saskia Calton | | Yes |
| E-mail: | saskia.calton@northyorks.gov.uk | | Yes |
| Contact number: | 01609 767226 | | 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 HWB is expected to sign off the plan: | Fri 19/07/2024 | << Please enter using the format, DD/MM/YYYY | Yes |

| | Role: | Professional Title (e.g. Dr, Cllr, Prof) | First-name: | Surname: | E-mail: | Complete: |
|---|---|---|---|---|---|---|
| *Area Assurance Contact Details: | Health and Wellbeing Board Chair | Mr | Michael | Harrison | Cllr.Michael.Harrison@northyorks.gov.uk | Yes |
| | Integrated Care Board Chief Executive or person to whom they have delegated sign-off | Mr | Steven | Eames | stephen.eames3@nhs.net | Yes |
| | Additional ICB(s) contacts if relevant | Mrs | Wendy | Balmain | wendy.balmain@nhs.net | Yes |
| | Local Authority Chief Executive | Mr | Richard | Flinton | richard.flinton@northyorks.gov.uk | Yes |
| | Local Authority Director of Adult Social Services (or equivalent) | Mr | Richard | Webb | richard.webb@northyorks.gov.uk | Yes |
| | Better Care Fund Lead Official | Mrs | Louise | Wallace | louise.wallace@northyorks.gov.uk | Yes |
| | LA Section 151 Officer | Mr | Gary | Fielding | gary.fielding@northyorks.gov.uk | Yes |
| *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 -->* | | | | | |

OFFICIAL

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

# Better Care Fund 2024-25 Update Template

## 3. Summary

Selected Health and Wellbeing Board: North Yorkshire

## Income & Expenditure

Income >>

| Funding Sources | Income | Expenditure | Difference |
|---|---|---|---|
| DFG | £5,579,105 | £5,579,105 | £0 |
| Minimum NHS Contribution | £51,519,368 | £51,519,368 | £0 |
| iBCF | £17,328,446 | £17,328,446 | £0 |
| Additional LA Contribution | £0 | £0 | £0 |
| Additional ICB Contribution | £0 | £0 | £0 |
| Local Authority Discharge Funding | £4,049,035 | £4,049,035 | £0 |
| ICB Discharge Funding | £5,021,336 | £5,021,336 | £0 |
| **Total** | **£83,497,290** | **£83,497,290** | **£0** |

Expenditure >>

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

| | 2024-25 |
|---|---|
| Minimum required spend | £14,518,973 |
| Planned spend | £26,056,856 |

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

| | 2024-25 |
|---|---|
| Minimum required spend | £19,213,378 |
| Planned spend | £19,213,378 |

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) | 125.1 | 118.9 | 135.5 | 131.5 |

## 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 | 1,757.0 | 1,730.5 |
| | Count | 2754 | 2441 |
| | Population | 155016 | 139416 |

## 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) | 92.3% | 92.5% | 92.8% | 93.0% |
|---|---|---|---|---|

## 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 | 665 | 376 |

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: North Yorkshire

Checklist

Complete:

Hospital Discharge

| Capacity - Demand (positive is Surplus) | Capacity surplus. Not including spot purchasing | | | | | | | | | | | | Capacity surplus (including spot puchasing) | | | | | | | | | | | | Checklist |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | 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) | -118 | -97 | -113 | -106 | -110 | -103 | -53 | -58 | -28 | -16 | -28 | -71 | -118 | -97 | -113 | -106 | -110 | -103 | -53 | -58 | -28 | -16 | -28 | -71 | Yes |
| Short term domiciliary care (pathway 1) | 151 | 182 | 151 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 229 | 266 | 226 | 95 | 80 | 82 | 90 | 88 | 95 | 99 | 89 | 67 | Yes |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | -7 | -48 | -54 | -30 | -27 | -30 | -51 | -47 | -37 | -27 | -30 | -32 | -7 | -48 | -54 | -30 | -27 | -30 | -51 | -47 | -37 | -27 | -30 | -32 | Yes |
| Other short term bedded care (pathway 2) | -45 | -45 | -46 | -45 | -46 | -45 | -45 | -45 | -45 | -45 | -45 | -45 | 9 | 23 | 20 | 9 | -8 | -9 | 6 | 2 | 0 | 14 | 8 | -4 | Yes |
| Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3) | -25 | -26 | -26 | -26 | -26 | -25 | -26 | -25 | -26 | -26 | -25 | -26 | -6 | -1 | -5 | -3 | -12 | -11 | -5 | -4 | -9 | -9 | -3 | -16 | Yes |

| Average LoS/Contact Hours per episode of care | |
|---|---|
| Full Year | Units |
| 8.75 | Contact Hours per package |
| 11.93 | Contact Hours per package |
| 23 | Average LoS (days) |
| 44 | Average LoS (days) |
| 34 | Average LoS (days) |

**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.**

Home from hospital service, which provides services such as shopping, prescription collection and liason with heath and social care staff, operates across North Yorkshire with delivering services 2,660 patient a year (HFH 2,000 and extra cacapity 660). In addition, service provision of 500 additional patients above commission capacity.

Checklist: Yes

## Capacity - Hospital Discharge

| Service Area | Metric | Refreshed planned capacity (not including spot purchased capacity | | | | | | | | | | | | Capacity that you expect to secure through spot purchasing | | | | | | | | | | | | Checklist |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | 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. | 180 | 205 | 191 | 198 | 195 | 194 | 247 | 241 | 273 | 287 | 265 | 231 | 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) | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 3 | 3 | 3 | 3 | 3 | | | | | | | | | | | | | Yes |
| Short term domiciliary care (pathway 1) | Monthly capacity. Number of new packages commenced. | 151 | 182 | 151 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 78 | 84 | 75 | 95 | 80 | 82 | 90 | 88 | 95 | 99 | 89 | 67 | Yes |
| Short term domiciliary care (pathway 1) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 7 | 7 | 7 | 6 | 6 | 6 | 5 | 5 | 5 | 4 | 4 | 4 | | | | | | | | | | | | | Yes |
| Reablement & Rehabilitation in a bedded setting (pathway 2) | Monthly capacity. Number of new packages commenced. | 133 | 95 | 87 | 113 | 116 | 110 | 92 | 93 | 106 | 116 | 104 | 111 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 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) | 8 | 8 | 8 | 7 | 7 | 7 | 6 | 6 | 6 | 5 | 5 | 5 | | | | | | | | | | | | | 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 | 54 | 68 | 66 | 54 | 38 | 36 | 51 | 47 | 45 | 59 | 53 | 41 | Yes |
| Other short term bedded care (pathway 2) | Estimated average time from referral to commencement of service (days) All packages (planned and spot purchased) | 10 | 10 | 10 | 9 | 9 | 9 | 8 | 8 | 8 | 7 | 7 | 7 | | | | | | | | | | | | | 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. | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 19 | 25 | 21 | 23 | 14 | 14 | 21 | 21 | 17 | 17 | 22 | 10 | 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) | 11 | 11 | 11 | 10 | 10 | 10 | 9 | 9 | 9 | 8 | 8 | 8 | | | | | | | | | | | | | 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 | Checklist |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total Expected Discharges:** | Total Discharges | **518** | **526** | **527** | **528** | **530** | **517** | **524** | **519** | **525** | **527** | **507** | **526** | Yes |
| Reablement & Rehabilitation at home (pathway 1) | Total | **298** | **302** | **304** | **304** | **305** | **297** | **300** | **299** | **301** | **303** | **293** | **302** | Yes |
| | HARROGATE AND DISTRICT NHS FOUNDATION TRUST | 118 | 118 | 118 | 118 | 118 | 118 | 118 | 118 | 118 | 118 | 118 | 118 | Yes |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU | 80 | 83 | 80 | 83 | 83 | 80 | 83 | 80 | 83 | 83 | 75 | 83 | Yes |
| | OTHER | 100 | 101 | 106 | 103 | 104 | 99 | 99 | 101 | 100 | 102 | 100 | 101 | 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 |
| | HARROGATE AND DISTRICT NHS FOUNDATION TRUST | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU | 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 |
| | (blank) | | | | | | | | | | | | | Yes |
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| **Reablement & Rehabilitation in a bedded setting (pathway 2)** | Total | **140** | **143** | **141** | **143** | **143** | **140** | **143** | **140** | **143** | **143** | **134** | **143** | Yes |
| | HARROGATE AND DISTRICT NHS FOUNDATION TRUST | 57 | 57 | 57 | 57 | 57 | 57 | 57 | 57 | 57 | 57 | 57 | 57 | Yes |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU | 73 | 76 | 73 | 76 | 76 | 73 | 76 | 73 | 76 | 76 | 68 | 76 | Yes |
| | OTHER | 10 | 10 | 11 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 9 | 10 | Yes |
| | (blank) | | | | | | | | | | | | | Yes |
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| **Other short term bedded care (pathway 2)** | Total | **45** | **45** | **46** | **45** | **46** | **45** | **45** | **45** | **45** | **45** | **45** | **45** | Yes |
| | HARROGATE AND DISTRICT NHS FOUNDATION TRUST | 19 | 19 | 19 | 18 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | 19 | Yes |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU | 17 | 17 | 17 | 17 | 17 | 17 | 17 | 17 | 17 | 17 | 16 | 17 | Yes |
| | OTHER | 9 | 9 | 10 | 10 | 10 | 9 | 9 | 9 | 9 | 9 | 10 | 9 | Yes |
| | (blank) | | | | | | | | | | | | | Yes |
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| **Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)** | Total | **35** | **36** | **36** | **36** | **36** | **35** | **36** | **35** | **36** | **36** | **35** | **36** | Yes |
| | HARROGATE AND DISTRICT NHS FOUNDATION TRUST | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | Yes |
| | YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRU | 11 | 12 | 11 | 12 | 12 | 11 | 12 | 11 | 12 | 12 | 11 | 12 | Yes |
| | OTHER | 9 | 9 | 10 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | 9 | Yes |
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## Better Care Fund 2024-25 Update Template

**4. Capacity & Demand**

Selected Health and Wellbeing Board: North Yorkshire

**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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | Contact Hours | Yes |
| Reablement & Rehabilitation at home | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8.75 | Contact Hours | Yes |
| Reablement & Rehabilitation in a bedded setting | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 22 | 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 | Complete |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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. | 545 | 571 | 590 | 591 | 591 | 610 | 646 | 645 | 646 | 646 | 644 | 646 | Yes |
| Reablement & Rehabilitation at home | Monthly capacity. Number of new clients. | 211 | 283 | 263 | 269 | 251 | 289 | 285 | 284 | 278 | 300 | 302 | 279 | Yes |
| Reablement & Rehabilitation in a bedded setting | Monthly capacity. Number of new clients. | 19 | 23 | 19 | 40 | 42 | 30 | 41 | 43 | 39 | 56 | 40 | 50 | Yes |
| Other short-term social care | Monthly capacity. Number of new clients. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 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 | Complete |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social support (including VCS) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |
| Urgent Community Response | 545 | 571 | 590 | 591 | 591 | 610 | 646 | 645 | 646 | 646 | 644 | 646 | Yes |
| Reablement & Rehabilitation at home | 211 | 283 | 263 | 269 | 251 | 289 | 285 | 284 | 278 | 300 | 302 | 279 | Yes |
| Reablement & Rehabilitation in a bedded setting | 19 | 23 | 19 | 40 | 42 | 30 | 41 | 43 | 39 | 56 | 40 | 50 | Yes |
| Other short-term social care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Yes |

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# Better Care Fund 2024-25 Update Template

## 5. Income

Selected Health and Wellbeing Board: North Yorkshire

| Local Authority Contribution | | |
|---|---|---|
| Disabled Facilities Grant (DFG) | Gross Contribution | Complete: |
| North Yorkshire | £5,579,105 | Yes |
| | | |
| DFG breakdown for two-tier areas only (where applicable) | | |
| Craven | £689,131 | |
| Hambleton | £590,512 | |
| Harrogate | £900,645 | |
| Richmondshire | £336,942 | |
| Ryedale | £722,533 | |
| Scarborough | £1,790,338 | |
| Selby | £549,004 | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Total Minimum LA Contribution (exc iBCF)** | **£5,579,105** | |

| Local Authority Discharge Funding | Contribution | |
|---|---|---|
| North Yorkshire | £4,049,035 | Yes |

| ICB Discharge Funding | Previously entered | Updated | Comments - Please use this box to clarify any specific uses or sources of funding | |
|---|---|---|---|---|
| NHS Humber and North Yorkshire ICB | £4,738,905 | £4,738,905 | | Yes |
| NHS Lancashire and South Cumbria ICB | £58,561 | £82,431 | | |
| NHS West Yorkshire ICB | £131,018 | £200,000 | | |
| **Total ICB Discharge Fund Contribution** | £4,928,484 | £5,021,336 | | |

| iBCF Contribution | Contribution | |
|---|---|---|
| North Yorkshire | £17,328,446 | Yes |
| | | |
| **Total iBCF Contribution** | **£17,328,446** | |

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

Yes

| NHS Minimum Contribution | Contribution |
|---|---|
| NHS Lancashire and South Cumbria ICB | £502,733 |
| NHS Humber and North Yorkshire ICB | £46,759,507 |
| NHS West Yorkshire ICB | £4,257,128 |
| | |
| | |
| | |
| | |
| **Total NHS Minimum Contribution** | **£51,519,368** |

| Additional ICB Contribution | Previously entered | Updated | Comments - Please use this box clarify any specific uses or sources of funding |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |
| **Total Additional NHS Contribution** | **£0** | **£0** | |
| **Total NHS Contribution** | **£51,519,368** | **£51,519,368** | |

| | 2024-25 |
|---|---|
| **Total BCF Pooled Budget** | **£83,497,290** |

| Funding Contributions Comments<br>Optional for any useful detail e.g. Carry over |
|---|
| DFG no longer split between districts. North Yorkshire is now a unitary council, all funding held by the NYC LA |

**See next sheet for Scheme Type (and Sub Type) descriptions**

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

**6. Expenditure**

**To Add New Schemes**

Selected Health and Wellbeing Board: North Yorkshire

<< Link to summary sheet

| Running Balances | 2024-25 Income | Expenditure | Balance |
|---|---|---|---|
| DFG | £5,579,105 | £5,579,105 | £0 |
| Minimum NHS Contribution | £51,519,368 | £51,519,368 | £0 |
| iBCF | £17,328,446 | £17,328,446 | £0 |
| Additional LA Contribution | £0 | £0 | £0 |
| Additional NHS Contribution | £0 | £0 | £0 |
| Local Authority Discharge Funding | £4,049,035 | £4,049,035 | £0 |
| ICB Discharge Funding | £5,021,336 | £5,021,336 | £0 |
| **Total** | **£83,497,290** | **£83,497,290** | **£0** |

**Required Spend**

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

| | 2024-25 Minimum Required Spend | Planned Spend | Under Spend |
|---|---|---|---|
| NHS Commissioned Out of Hospital spend from the minimum ICB allocation | £14,518,973 | £26,056,856 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £19,213,378 | £19,213,378 | £0 |

**Checklist**

Column complete:

| 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 | Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) | Provider | Source of Funding | New/ Existing Scheme | Previously entered Expenditure for 2024-25 | Updated Expenditure for 2024-25 (£) | % of Overall Spend (Average) | Do you wish to update? | Comments if updated e.g. reason for the changes made |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | Yes | Yes | Yes | Yes | Yes | | | | Yes | Yes | Yes | Yes | | Yes | No | Yes | | Yes | | Yes | Yes |

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

67, 68, 73, 74, 75, 78, 80, 81, 82, 83, 84, 85, 87, 91, 92, 93, 94, 95, 96, 98, 99, 100, 101, 103, 107, 109, 115, 116, 117, 118, 119, 124, 125, 126, 127, 128, 272, 273, 274, 275, 276, 277, 278, 279, 280

| | | | | | | | | | Planned Expenditure | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) | Provider | Source of Funding | New/ Existing Scheme | Previously entered Expenditure for 2024-25 | Updated Expenditure for 2024-25 (£) | % of Overall Spend (Average) | Do you wish to update? | Comments if updated e.g. reason for the changes made |
| 1 | iBCF - Quality Improvement Team | Care Sector improvement programme: Quality Improvement Team, Training | Other | | Nursing Home | | | | Social Care | | LA | | | Private Sector | iBCF | Existing | £100,000 | | 0% | No | |
| 2 | iBCF - Centre of Excellence | Set up costs for 'centre of excellence' for recruitment in the care sector | Other | | Recruitment | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £181,000 | | 0% | No | |
| 3 | iBCF - Intergrated Health & Care staffing | Intergrated Health & Care staffing | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £411,000 | | 24% | No | |
| 4 | iBCF - Living Well | Extend Living Well capacity | Prevention / Early Intervention | Social Prescribing | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £328,000 | | 2% | No | |
| 5 | iBCF - 7 Day Working | 7 day working - Additional social care capacity or new 'inpatient navigator' | High Impact Change Model for Managing Transfer of Care | Flexible working patterns (including 7 day working) | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £530,000 | | 55% | No | |
| 6 | iBCF - ASC Funding Pressures | Adult Social Care funding pressures | High Impact Change Model for Managing Transfer of Care | Early Discharge Planning | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £876,000 | | 0% | No | |
| 7 | iBCF - Care & Support Phase 2 | Care Act Implementation Related Duties | Carers Services | Carer advice and support related to Care Act duties | | 25 | | Beneficiaries | Social Care | | LA | | | Local Authority | iBCF | New | £990,000 | | 0% | No | |
| 8 | DFG schemes | DFG schemes via District Councils | DFG Related Schemes | Adaptations, including statutory DFG grants | | 798 | 798 | Number of adaptations funded/people | Social Care | | LA | | | Local Authority | DFG | Existing | £5,114,924 | £5,579,105 | 100% | Yes | Increased funding for 24/25 - retained within NYC, from 23/24 as now unitary |
| 9 | Home from hospital capacity | Increase Home from Hospital capacity | Prevention / Early Intervention | Other | Support for pathway 0 | | | | Social Care | | LA | | | Charity / Voluntary Sector | Local Authority Discharge | Existing | £42,150 | | 0% | No | |
| 10 | Intermediate Care Hubs | Increase capacity within Intermediate Care hubs | Integrated Care Planning and Navigation | Assessment teams/joint assessment | | | | | Social Care | | LA | | | Local Authority | Local Authority Discharge | New | £916,315 | £969,371 | 54% | Yes | Pay award increase |
| 11 | Hospital Discharge Support | Hospital discharge support posts | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Social Care | | LA | | | Local Authority | Local Authority Discharge | New | £179,813 | £37,467 | 11% | Yes | Reduction in support |
| 12 | Bed-based intermediate care | Bed-based Intermediate Care | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement (to support discharge) | | 22 | 22 | Number of placements | Social Care | | LA | | | Local Authority | Local Authority Discharge | Existing | £1,016,143 | £1,003,733 | 41% | Yes | review of occupancy led to change in location of beds |
| 13 | Flexible Domiciliary Care | Increase flexible domiciliary care capacity | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess | | 10333 | 14154 | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | Local Authority Discharge | New | £275,000 | £376,700 | 0% | Yes | Scheme now named home first - intermediate care and grant allocation and output has increased due to extended timeline of Bridging services in 2024/25 |
| 14 | iBCF - ASC Funding Pressures | Adult Social Care funding pressures | High Impact Change Model for Managing Transfer of Care | Early Discharge Planning | | | | | Social Care | | LA | | | Local Authority | iBCF | Existing | £13,912,446 | | 5% | No | |
| 15 | VOY - Hospice at Home (extended hours) | Care home support | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess | | 6442 | 6442 | Hours of care (Unless short-term in which | Community Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £193,274 | £174,298 | 0% | Yes | differential uplift applied |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | VOY - Selby Care Hub | Community services | Community Based Schemes | Integrated neighbourhood services | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £1,082,852 | £1,090,591 | 1% | Yes | differential uplift applied |
| 17 | VOY - Street Triage service (part fund with CYC) | MH crisis response | Community Based Schemes | Other | MH Crisis response | | | | Mental Health | | NHS | | | NHS Mental Health Provider | Minimum NHS Contribution | Existing | £175,383 | £173,019 | 0% | Yes | differential uplift applied |
| 18 | VOY - Urgent Care Practitioners | Community based emergency response | Community Based Schemes | Integrated neighbourhood services | | | | | Community Health | | NHS | | | NHS Acute Provider | Minimum NHS Contribution | Existing | £309,144 | £301,936 | 0% | Yes | differential uplift applied |
| 19 | VOY - s256 care home support | Care home support | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess | | 1015 | 1015 | Hours of care (Unless short-term in which | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £30,452 | £37,008 | 0% | Yes | differential uplift applied |
| 20 | VOY - s256 carers support | Carers support | Carers Services | Respite services | | 2 | 2 | Beneficiaries | Social Care | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £38,743 | £31,611 | 10% | Yes | differential uplift applied |
| 21 | VOY - CCG Out of Hospital commission | Community services | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £5,243,835 | £5,265,845 | 7% | Yes | differential uplift applied |
| 22 | VOY - NYC Social care protection | Social care protection | Home Care or Domiciliary Care | Domiciliary care packages | | 131793 | 131793 | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £3,953,799 | £3,963,777 | 1% | Yes | differential uplift applied |
| 23 | VOY - Selby UTC+ | Community services enhancement | Community Based Schemes | Integrated neighbourhood services | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £101,800 | £100,600 | 0% | Yes | differential uplift applied |
| 24 | NY community nursing services | NY Community Nursing Services | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Community Health | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £14,007,608 | £12,892,761 | 17% | Yes | differential uplift applied |
| 25 | NY voluntary sector projects | NY voluntary sector projects | Community Based Schemes | Other | Various voluntary sector provider schemes | | | | Community Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £125,365 | £96,209 | 0% | Yes | differential uplift applied |
| 26 | NY palliative care pathway | NY palliative care pathway | Community Based Schemes | Other | End of life care support at home | | | | Community Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £809,183 | £1,245,520 | 1% | Yes | 2.9% uplift applied for Hospices |
| 27 | NY voluntary sector support s256 | VCSE infrastructure support service | Enablers for Integration | Joint commissioning infrastructure | | | | | Community Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £145,053 | £143,343 | 98% | Yes | differential uplift applied |
| 28 | NY advocacy s256 | NY advocacy | Care Act Implementation Related Duties | Independent Mental Health Advocacy | | | | | Community Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £61,357 | £60,634 | 37% | Yes | differential uplift applied |
| 29 | NY carers s256 | NY carers | Carers Services | Other | Carer support and assessments | 8 | 8 | Beneficiaries | Community Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £229,043 | £222,415 | 59% | Yes | differential uplift applied |
| 30 | NY Dementia s256 | Dementia support service | Integrated Care Planning and Navigation | Care navigation and planning | | | | | Mental Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £49,257 | £71,311 | 3% | Yes | differential uplift applied |
| 31 | NY step up / down | NY step up / down | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement accepting step up and step | | 62 | 62 | Number of placements | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution | Existing | £324,674 | £346,075 | 13% | Yes | differential uplift applied |
| 32 | NY wheelchairs | Wheelchair services | Assistive Technologies and Equipment | Community based equipment | | 2468 | 2468 | Number of beneficiaries | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution | Existing | £1,551,292 | £1,869,063 | 24% | Yes | differential uplift applied |
| 33 | NY Equipment | Community Equipment | Assistive Technologies and Equipment | Community based equipment | | 26904 | 26904 | Number of beneficiaries | Community Health | | LA | | | Private Sector | Minimum NHS Contribution | Existing | £2,612,117 | £2,850,108 | 40% | Yes | differential uplift applied |
| 34 | NY psychiatric liaison | NY psychiatric liaison | Prevention / Early Intervention | Other | Mental health support | | | | Mental Health | | NHS | | | NHS Mental Health Provider | Minimum NHS Contribution | Existing | £898,720 | £882,922 | 6% | Yes | differential uplift applied |
| 35 | NY care home support | NY care home support | Community Based Schemes | Other | Mental health support into care homes | | | | Mental Health | | NHS | | | NHS Mental Health Provider | Minimum NHS Contribution | Existing | £45,773 | £44,968 | 0% | Yes | differential uplift applied |
| 36 | NY Community mental (IAPT) | NY Community mental (IAPT) | Prevention / Early Intervention | Other | Psychological therapies | | | | Mental Health | | NHS | | | NHS Mental Health Provider | Minimum NHS Contribution | Existing | £795,462 | £781,479 | 5% | Yes | differential uplift applied |
| 37 | NY community mental health support | NY community mental health support | Prevention / Early Intervention | Other | Support to veterans & mental health | | | | Mental Health | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £17,707 | £43,583 | 0% | Yes | now includes community counselling |
| 38 | NY alcohol worker | NY alcohol worker | Prevention / Early Intervention | Other | Alcohol worker | | | | Mental Health | | NHS | | | Private Sector | Minimum NHS Contribution | Existing | £69,408 | £0 | 0% | Yes | withdrawn |
| 39 | NY primary care nursing workforce - GP frailty | NY primary care nursing workforce - GP frailty | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | Primary Care | | NHS | | | NHS | Minimum NHS Contribution | Existing | £440,530 | £432,741 | 1% | Yes | LES no inflation |
| 40 | NY protection of social care | NY protection of social care | Home Care or Domiciliary Care | Domiciliary care packages | | 438904 | 438904 | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £13,167,127 | £13,405,863 | 4% | Yes | differential uplift applied |
| 41 | NY living well coordinators | NY living well coordinators | Prevention / Early Intervention | Social Prescribing | | | | | Community Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £69,952 | £67,500 | 0% | Yes | already invoiced for 24-25 |
| 42 | NY generic workers in the community s256 | NY generic workers in the community | Community Based Schemes | Integrated neighbourhood services | Integrated models of provision | | | | Community Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £86,398 | £85,379 | 0% | Yes | differential uplift applied |
| 43 | NY community transport s256 | NY community transport | Community Based Schemes | Integrated neighbourhood services | | | | | Community Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £39,383 | £38,919 | 0% | Yes | differential uplift applied |
| 44 | NY community mental health & wellbeing s256 | NY community mental health & wellbeing | Prevention / Early Intervention | Other | M/H schemes covering prevention, | | | | Mental Health | | LA | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £84,815 | £40,030 | 1% | Yes | differential uplift applied |
| 45 | NY Time to think beds | Increase in packages to reduce delayed discharge | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | | 88 | | Number of placements | Community Health | | LA | | | Private Sector | ICB Discharge Funding | Existing | £400,000 | | 16% | No | |

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| 46 | NY Fast Track packages | Community based support packages for EOL | Home Care or Domiciliary Care | Other | EOL Home Care or Domiciliary Care | 7444 | | Hours of care (Unless short-term in which | Community Health | | LA | | | Private Sector | ICB Discharge Funding | Existing | £1,000,000 | £1,000,195 | 0% | Yes | differential uplift applied |
| 47 | NY Additional community domiciliary care | Community based EOL domiciliary care to meet increased demand | Home Care or Domiciliary Care | Domiciliary care packages | Community based support packages for EOL | 470 | 0 | Hours of care (Unless short-term in which | Community Health | | LA | | | Private Sector | ICB Discharge Funding | New | £100,000 | £0 | 0% | Yes | withdrawn |
| 48 | NY Equipment management | Additional equipment costs to support discharge plus co-ordinator role | Assistive Technologies and Equipment | Community based equipment | | 115 | | Number of beneficiaries | Community Health | | NHS | | | Private Sector | ICB Discharge Funding | Existing | £109,000 | | 2% | No | |
| 49 | NY LDA Community Access Grant | LDA Community Access Grant | Community Based Schemes | Integrated neighbourhood services | | | | | Mental Health | | NHS | | | NHS Mental Health Provider | ICB Discharge Funding | New | £134,000 | | 0% | No | |
| 50 | NY Learning Disabilities | LDA intensive support team | Integrated Care Planning and Navigation | Support for implementation of anticipatory care | | | | | Mental Health | | NHS | | | NHS Mental Health Provider | ICB Discharge Funding | Existing | £250,000 | £500,000 | 15% | Yes | differential uplift applied |
| 51 | NY FHN Discharge facilitators | FHN Discharge facilitators | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | | | | | Community Health | | NHS | | | NHS Community Provider | ICB Discharge Funding | Existing | £156,000 | | 16% | No | |
| 52 | NY Home First | Home first discharge support | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | | | | | Community Health | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | £374,000 | £150,000 | 39% | Yes | differential uplift applied |
| 53 | NY Personal health budgets | Personal health budgets | Personalised Budgeting and Commissioning | | | | | | Community Health | | LA | | | Charity / Voluntary Sector | ICB Discharge Funding | Existing | £5,000 | | 0% | No | |
| 54 | NY Home from hospital capacity | Extended capacity for home from hospital | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess | | 5067 | 5067 | Hours of care (Unless short-term in which | Community Health | | LA | | | Charity / Voluntary Sector | ICB Discharge Funding | Existing | £152,000 | £151,950 | 0% | Yes | differential uplift applied |
| 55 | NY Increased complex care capacity | Additional beds for dementia or complex needs | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement accepting step up and step | | 26 | 0 | Number of placements | Community Health | | LA | | | NHS Community Provider | ICB Discharge Funding | Existing | £229,000 | £0 | 9% | Yes | withdrawn |
| 56 | NY Additional CHC assessment capacity | Additional CHC assessment capacity to support timely discharge | Workforce recruitment and retention | | | | | WTE's gained | Community Health | | NHS | | | NHS | ICB Discharge Funding | Existing | £250,000 | | 100% | No | |
| 57 | NY Additional block booked beds | Additional block booked beds | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | | 26 | 26 | Number of placements | Community Health | | NHS | | | Private Sector | ICB Discharge Funding | Existing | £189,000 | £57,000 | 8% | Yes | differential uplift applied |
| 58 | L&SC protection of social care | NY protection of social care | Home Care or Domiciliary Care | Domiciliary care packages | | 6260 | | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £187,489 | £187,487 | 0% | Yes | differential uplift applied |
| 59 | L&SC Additional community domiciliary care | Community based EOL domiciliary care to meet increased demand | Home Care or Domiciliary Care | Domiciliary care packages | Community based support packages for EOL | 10508 | | Hours of care (Unless short-term in which | Community Health | | NHS | | | Private Sector | Minimum NHS Contribution | Existing | £315,245 | £315,246 | 0% | Yes | differential uplift applied |
| 60 | WY Community Equipment | Providing equipment to patients at home | Assistive Technologies and Equipment | Community based equipment | | 305 | | Number of beneficiaries | CCG | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £307,016 | £293,874 | 5% | Yes | differential uplift applied |
| 61 | WY Re-ablement Services | Support to patients in own home to improve confidence and ability to live as | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | CCG | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £187,165 | £408,212 | 0% | Yes | differential uplift applied |
| 62 | WY Collaborative Care Team | Community support schemes | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | CCG | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £541,706 | £470,087 | 1% | Yes | differential uplift applied |
| 63 | WY Intermediate Care Beds | Short-term intervention to preserve the independence of people who might | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement (to support discharge) | | 38 | 38 | Number of placements | CCG | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £281,085 | £430,700 | 17% | Yes | differential uplift applied |
| 64 | WY Carers Support | Support to carers | Carers Services | Other | Carer support and assessments | 2 | 2 | Beneficiaries | CCG | | NHS | | | Charity / Voluntary Sector | Minimum NHS Contribution | Existing | £51,306 | £45,000 | 13% | Yes | differential uplift applied |
| 65 | WY Carers Support | Support to carers | Carers Services | Other | Carer support and assessments | 2 | 2 | Beneficiaries | CCG | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £21,785 | £21,785 | 5% | Yes | differential uplift applied |
| 66 | WY Intermediate Care Beds | Short-term intervention to preserve the independence of people who might | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with reablement (to support discharge) | | 16 | 16 | Number of placements | CCG | | NHS | | | Private Sector | Minimum NHS Contribution | Existing | £119,714 | £73,500 | 5% | Yes | differential uplift applied |
| 67 | WY Local schemes | Community support schemes | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | CCG | | NHS | | | NHS Community Provider | Minimum NHS Contribution | Existing | £573,430 | £658,737 | 1% | Yes | differential uplift applied |
| 68 | WY Local schemes | Community support schemes | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | CCG | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £36,001 | £36,000 | 0% | Yes | differential uplift applied |
| 69 | WY Local schemes | Community support schemes | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | CCG | | NHS | | | Private Sector | Minimum NHS Contribution | Existing | £220,956 | £117,425 | 0% | Yes | differential uplift applied |
| 70 | WY Local schemes | Community support schemes | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as | | | | | CCG | | NHS | | | Private Sector | Minimum NHS Contribution | Existing | £81,196 | £114,175 | 0% | Yes | differential uplift applied |
| 71 | WY Protection of Social Care | Working in partnership with Local Authority to maintain and support social services | Home Care or Domiciliary Care | Domiciliary care packages | | 60383 | | Hours of care (Unless short-term in which | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £1,811,500 | £1,563,364 | 60% | Yes | differential uplift applied |
| 72 | WY Other Equipment and technologies | Providing equipment to patients at home | Assistive Technologies and Equipment | Community based equipment | | 24 | | Number of beneficiaries | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | Existing | £24,268 | | 0% | No | |
| 73 | WY Reablement Services | To support investment in the reablement service which supports with timely | Home-based intermediate care services | Reablement at home (to support discharge) | | 4 | 4 | Packages | Social Care | | LA | | | Local Authority | ICB Discharge Funding | Existing | £131,018 | £200,000 | 1% | Yes | Increase in allocation |
| 74 | L&SC Reablement Services | To support investment in the reablement service which supports with timely | Home-based intermediate care services | Reablement at home (to support discharge) | | 2 | 2 | Packages | Social Care | | LA | | | Local Authority | ICB Discharge Funding | Existing | £58,561 | £82,431 | 1% | Yes | Increase in allocation |
| 75 | NY Discharge schemes (to be identified) | Discharge schemes (to be identified) | Other | | | | 0 | | Community Health | | NHS | | | Private Sector | ICB Discharge Funding | New | £1,390,905 | £0 | 0% | Yes | schemes identified as new below |

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| 76 | NY Discharge schemes (to be identified) | Discharge schemes (to be identified) | Other | | | | 0 | | Social Care | | LA | | | Local Authority | Local Authority Discharge | New | £1,603,418 | £0 | 0% | Yes | schemes identified as new below |
| | | | | | | | | | | | | | | | | | | | | | |

## Adding New Schemes:

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| 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 | New/ Existing Scheme | | Expenditure for 2024-25 (£) | % of Overall Spend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 76 | Discharge costs | Discharge Schemes | Other | | | | | | Social Care | | LA | | | Local Authority | Local Authority Discharge | New | | £1,619,614 | 40% |
| 77 | Y&SHFT - additional discharge co- | Y&SHFT - additional discharge co-ordinator | High Impact Change Model for Managing Transfer of Care | Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge | | | 1 | | Acute | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | | £50,000 | 1% |
| 78 | Therapy - South Tees Therapy in-reach (Friary and | Therapy - South Tees Therapy in-reach (Friary and IC beds) | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation accepting step up and step | | | To be developed in 2024/25 | Number of placements | Acute | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | | £200,000 | 4% |
| 79 | Therapy - HARA Therapy in-reach (Station View) | Therapy - HARA Therapy in-reach (Station View) | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation accepting step up and step | | | To be developed in 2024/25 | Number of placements | Community Health | | NHS | | | Private Sector | ICB Discharge Funding | New | | £177,000 | 4% |
| 80 | Therapy - Humber FT Home First Discharge | Therapy - Humber FT Home First Discharge (including Whitby post) | Home-based intermediate care services | Joint reablement and rehabilitation service (to support discharge) | | | To be developed in 2024/25 | Packages | Community Health | | NHS | | | NHS Mental Health Provider | ICB Discharge Funding | New | | £395,000 | 8% |
| 81 | Therapy - STHFT Home First Discharge H&R | Therapy - STHFT Home First Discharge H&R | Home-based intermediate care services | Joint reablement and rehabilitation service (to support discharge) | | | To be developed in 2024/25 | Packages | Acute | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | | £150,000 | 3% |
| 82 | Therapy - Additional in-reach therapy for Selby | Therapy - Additional in-reach therapy for Selby | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation accepting step up and step | | | To be developed in 2024/25 | Number of placements | Acute | | NHS | | | NHS Community Provider | ICB Discharge Funding | New | | £188,760 | 4% |
| 83 | LA linked costs - Non-weight bearing pathway | LA linked costs - Non-weight bearing pathway costs | Bed based intermediate Care Services (Reablement, | Bed-based intermediate care with rehabilitation (to support discharge) | | | 8 | Number of placements | Social Care | | NHS | | | Local Authority | ICB Discharge Funding | New | | £65,000 | 1% |
| 84 | LA linked costs - Bridging service to allow rapid | LA linked costs - Bridging service to allow rapid pathway 1 discharges within | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge (Discharge to Assess | | | 30 per week | Hours of care (Unless short-term in which | Social Care | | NHS | | | Local Authority | ICB Discharge Funding | New | | £600,000 | 13% |
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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 |

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|---|---|---|---|
| 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: North Yorkshire

**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

Checklist Complete:

Linked KLOEs (For information)

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

We've used commissioned capacity data for 23/24 as a baseline for capacity in the current plan. Likewise when predicting what we might need to spot purchase we've used last years actuals as baseline. This will be adjusted in year, depending on what our in year spot purchasing profiles like against last years.

There are currently reported shortfalls in pathway 1 provision. The model of delivery in this area is that all patients discharged on pathway 1 should be provided with reablement services and not domiciliary care. For this reason, we didn't consider it appropriate to include domiciliary care figures within demand. Due to recruitment issues, it has not been possible to deliver the level of reablement required in this model. As a result domiciliary care packages have been purchased to cover these shortfalls. The monies which were not spent on staffing these reablement vacancies was able to be redirected into supporting purchase of other care packages and bridging services. This additional domiciliary care capacity has been included in these figures.

Checklist: Yes

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?**

The LA has completed a demand and occupancy analysis of its current in house bed provision. Environments that were not conducive to recovery have been de -commissioned and beds increased in areas of higher demand and where therapy is available to support a timely discharge to a persons own home. Surplus funds have supported an increase from April to June 24 in pathway 1 provision with a bridging service to support rapid discharge. Both services offer step up to prevent hospital admission. Nursing beds on the East Coast have been commissioned following a gap analysis and have contributed to a lower NCTR figure at Scarborough Hospital. Any gaps in provision have been filled using spot purchased beds. Further review of services wil be comepleted with a view of stepping up over winter. All changes are reviewed through a weekly tactical group, which is able to review and adjust capacity in line with any gaps identified as the year progresses.

As per the question above we have had similar issues in not having enough reablement capacity to deliver our preferred model, hence including domiciliary care in capacity figures, but not in demand figures.

Checklist: Yes

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?**

There is ongoing work with equipment services and contracting to ensure increased provision and improved timeliness of delivery. The ability of community teams to have same day delivery of equipment can prevent admission and promote independence at home for longer.
Core community therapy services are working closely with all other community services including primary care, Urgent Community Response, Virtual Wards and reablement teams to maintain function and independence of patients at home and preventing hospital admissions or requirement for increases in care packages or long-term placements.
There are 22 commissioned step-up beds with wrap around therapy across North Yorkshire with 11 dual registered beds on the East Coast to support pressures from York and Scarborough. These allow patients to receive rehabilitation and reablement in a safe environment preventing their admission to hospital and receive goal focussed treatment targeting their return to their own home. We are supporting these plans with a contingency to step up further beds over times of significant pressure and over winter. There are also two admission avoidance beds, with therapy in-reach as required, which also prevent admission to the acute trust.

Checklist: Yes

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)?**

An integrated discharge hub has been established to facilitate faster and more appropriate discharges from acute hospital beds. This hub is focussed on a "home first" approach with discharge to assess integrated as much as possible. Home from hospital supports patients on pathway 0 to ensure that they can return home faster, reducing their acute length of stay and preventing further functional decline.
Pathway 1 discharges are also supported by the Home First Team in Hambleton and Richmondshire where an integrated therapy and reablement team can work with patients on goal-led rehabilitation and reablement to maximise independence and reduce dependency on any long-term care. The ARCH team in Harrogate provide therapy and reablement services where the model allows flexibility of staffing and service to wrap around the needs of the patient.
All hospital discharges across this area can be supported by core therapy teams as required to ensure that rehabilitation targets can be met with patients allowing them to reach their maximum potential.
There is ongoing work with equipment services and contracting to ensure increased provision and improved timeliness of delivery. Same day delivery of equipment is allowing more rapid discharge of patients from hospital and reducing length of stay.

Checklist: Yes

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.**

We have used the ICB operational plan, including the growth targets, as the basis for estimating the demand by pathway. This demand has been apportioned to the local authority estimate using actual emergency admissions by acute provider. Adjustments have been made to demand data after taking account of local intelligence, following a discussion between ICB and NY data leads.

Any shortfalls identified during the capacity and demand modelling will be considered alongside all data collected and national targets as part of a much larger intermediate care project. This is led by a multi-partner project board, which includes LA and NHS senior leaders, that is directing the development of a business case, underpinned by the capacity and demand data. There is a joint commissioning group between NYC and H&NY ICB which will be working across the region to improve these services and oversee and implement BCF schemes. With regard to specific shortfalls in beds, reablement provision and the need for a bridging service, there are planned workshops to match the BCF data with deep dives into specific services. This detail will then be used to plan future service provision. Ongoing review of the residential and nursing bedded provision is essential as the increase in intermediate care provision should reduce the demand in these areas.

Checklist: Yes

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.**

We have used the ICB operational plan, including the growth targets, as the basis for estimating the demand by pathway. This demand has been apportioned to the local authority estimate using actual emergency admissions by acute provider. As part of developing the intermediate care project workstreams for pathway 1 capacity, hub capacity and bed capacity has been obtained from all partners and modelled to bring together service changes with scheme requirements.

Checklist: Yes

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

### 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.**

The North Yorkshire ASCDF for the ICB has increased in value to £4.7m. The additional funding covers several key elements:

- A range of new therapy posts in community providers across the 4 different NHS community providers – these were commissioned in 2023/24 to support greater Home First capacity (pathway 1) and therapy in-reach into intermediate care facilities and beds (pathway 2) but the FYE of the full capacity appears in 24/25 – this should continue the process of improving length of stay within intermediate care facilities and creating additional pathway 1 capacity to bring people home quicker from hospital, as well as improving long term outcomes
- Formal adoption of a pathway for non-weight bearing patients who require an extended period of non-chargeable intermediate care to complete their rehabilitation following a fracture etc.
- Allocation of funding for a pathway 1 bridging service (to be commissioned in combination with North Yorkshire Council) that can utilise domiciliary care capacity from the care sector to 'bridge' the gap between rehabilitation and reablement services if these are not immediately available, to support an increase in pathway 1 capacity – this should reduce NCTR and discharge delays
- Full year effect of the Learning Disabilities Intensive Support Team (only 6 months funding was included in 2024/25)
- A new discharge role for the Scarborough system to support the discharge hub

NYC spot purchased provision for pathway 2 and 3 and domiciliary care

Yes

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)**

Having reviewed the Rapid Evaluation Discharge Funding 22/23 Publication we were able to recognise some of the challenges identified within our own evaluation of the previous year's planning and spend. The North Yorkshire system is starting to make an impact on NCTR and home first, particularly in the Scarborough system. However, all discharge plans have been reviewed between NYC and NY Place to determine their effectiveness. There are several key elements to the learning and hence a series of improvements and modifications to plans:

- Improvements to hub operating processes behaviours – focused on developing a true MDT approach, chaired by the hospital discharge lead, with effective participation from brokerage and reablement services and an actioned-focused culture where staff come prepared with updated information enabling hub teams to make live decisions while on daily operational calls. Recruiting to additional staff for the hubs was not wholly successful due to the funding being one off and not recurrent. Agency staff were appointed, this supported a quicker discharge and had a positive impact on NCTR. Working on the operational culture and process has helped maintain the impact.
- Commencing the utilisation of electronic Trusted Assessment Forms – being piloted at all acute hospitals and still being refined to get the level of detail optimised in line with provider needs
- Creating additional capacity for pathway 1 and 2 so that hubs are able to transfer patients more quickly and promptly.
- For pathway 1, this has focused on piloting the bridging service from January 2024 using winter UEC monies. Provision has been made for the full 2024/25 year within plans, and the service has been extended to the end of June 2024 – however a final business case will be needed before recommissioning, following a more detailed evaluation. Short term contracts were not supportive of providers and was another key area of learning, hence extending contracts for full year to support provider sustainability. Following on from an unsuccessful local campaign to recruit in house reablement staff, another challenge identified by the Government published review, we shifted some of the spend into the Commissioned Bridging Service for the latter part of 23/24.
- For pathway 2, this has involved revising and refining the intermediate care bed offer. A number of providers have ceased to provide as the level of occupancy and environment was not suitable – to be replaced with new providers (funded through a combination of NHS capacity fund and adult social care discharge fund). A full review of our current offer was completed and funds directed into localities were demand was high and therapy available to support the journey home. Purchasing beds without the therapy support is absolutely not conducive to a positive step on the journey home and has led to longer stays resulting in deconditioning, hence from 23/24 learning we have reduced the beds to be able to commission therapy which is a key component to successful rehab but remains a challenge with capacity in the system.

Yes

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?**

North Yorkshire has developed an effective Joint Commissioning Group during 2023/24 between NY Place and NYC, which allows plans to be jointly developed and co-ordinated. This JCG reports upwards to the joint NY Health and Care Management Group, which oversees expenditure at a Director-level.

This joint commissioning approach allows for a joint review of services, schemes, and budgets to develop new joint proposals, track expenditure and variations to plans, and recommend new developments. The following areas are regular items through the joint commissioning group:

- Development of VSCE sector and oversight of schemes commissioned within the BCF including through section 256 agreements (for jointly commissioned services)
- Plans for commissioning and procurement of equipment services
- Discharge schemes through the adult social care discharge fund (see also above)

Yes

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: North Yorkshire

### 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. | Complete: |
|---|---|---|---|---|---|---|---|---|
| Indirectly standardised rate (ISR) of admissions per 100,000 population<br><br>(See Guidance) | Indicator value | 189.5 | 185.1 | 135.2 | 134.0 | Plan based on: NY population (excluding Craven) excluding 0 los admissions:<br>(caveat: rates are based on the BCF AA tool which references observed admissions including 0 los; raw numbers below:)<br><br>Q1: 925: Q2: 879: Q3: 1002: Q4: 973<br>Whilst the target for this indicator was not achieved in 23/24, this was based on including all los. The plan for 24_25 excludes these admissions and therefore the baseline is a lot lower and hence the metric has been reset.<br><br>There is a 2.6%* increase expected in non elective admissions: BCF schemes are intended to mitigate this rise and the trajectory therefore is set to 0% growth from the 2023_24 estimate using the same counting methodology.<br><br>*The 2.6% is the unmitigated growth for NEL beds we used in our capacity demand and flow waterfall in the operational planning submission.<br><br>This was made up of a weighted population growth in the ICB of 0.3%, increasing acuity of patients who are presenting at A&E, an | •Use of 2 hourly UCR services and virtual wards to prevent people being admitted. These include medical care from GP's/Consultants and ACP's to provide a high level of medical cover<br>•2 admission avoidance beds in Hambleton & Richmondshire to enable the Hospital@Home team tomove people into for 24 hour care that don't need acute medical care. These beds have access to nursing and therapy input as needed<br>•End of Life care as needed with specialist palliative domiciliary care services/Marie Curie/Community Nursing<br>•Step up/Step down beds across Hambleton & Richmondshire to support people to regain their independence, don't need any acute care but are not safe to be left in their own home.<br>•Use of equipment and technology that can be accessed timely to prevent a hospital admission.<br>All BCF funding except UCR service | Yes |
| | Number of Admissions | 1,555 | 1,519 | - | - | | | |
| | Population | 618,847 | 618,847 | - | - | | | |
| | | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan | | | |
| | Indicator value | 125.1 | 118.9 | 135.5 | 131.5 | | | Yes |

[>> 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. | Complete: |
|---|---|---|---|---|---|---|---|
| | Indicator value | 1,616.4 | 1,757.0 | 1,730.5 | 2024_25 Plan based on: NY population (excluding Craven) excluding 0 los admissions.<br><br>Last year's plan is based on an estimate including Craven (hence the population size has been reset for 24/25) and also includes all los. The plan for 24/25 excludes the 0 los spells. | •A comprehensive falls strategy in place ( part of community budget funded by BCF however not specific schemes)<br>•Immedicare in many care homes that can be accessed 24 hours a day (not BCF funding)<br>•Falls workshops and falls webinar teaching have been rolled out across the county. (not BCF funding) | Yes |
| | Count | 2,542 | 2754 | 2441 | | | Yes |

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| Indicator | | | | | Rationale | Plan | |
|---|---|---|---|---|---|---|---|
| Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000. | Population | 155,016 | 155016 | 139416 | The plan is set to mitigate the planned 2.6%* growth and the trajectory is therefore set to 0% growth from the 2023_24 full year estimate using the same counting methodology. | •Funding available for independent providers to bid for to support falls prevention, this is approved via a panel (not BCF funding)<br>•Training and development from the Centre of Excellence for frailty (not BCF funding) | Yes |

[Public Health Outcomes Framework - Data - OHID (phe.org.uk)](https://fingertips.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 (%) | 91.4% | 92.3% | 92.0% | 92.0% | Plan based on NY population (excluding Craven), allowing for 2.6%* growth for total admissions on 2023_24 activity.<br><br>In 23/24 we were very close to the 92%. Our aim for 24/25 is to make on-going improvements in this metric, with the aim of a stretched target for 25/26, if improvements are made in year. As an interim we have set a revised stretched target as set out increasing to 93% in Q4. | There are several key schemes across North Yorkshire to support discharge back to their people's own home, these include:<br>•Home first pilot in Hambleton & Richmondshire that support people into their own home with reablement and therapy for up to 6 weeks to help them regain their independence.<br>•A bridging service to support an earlier discharge home until the brokered package of care can start.<br>•Virtual wards across North Yorkshire to support step down care from hospital.<br>•Home from hospital supporting step down care for people across Hambleton & Richmondshire.<br>•Community services including Community Nursing and Community Therapy<br>•End of Life care as needed with specialist palliative domiciliary care services/Marie Curie/Community Nursing<br>•Step up/Step down beds across Hambleton & Richmondshire to support people to regain their independence until they are safe to return home<br>(all BCF funding except virtual wards) | Yes |
| | Numerator | 12,882 | 13,087 | 9,621 | 9,574 | | | |
| | Denominator | 14,095 | 14,175 | 10,458 | 10,407 | | | |
| | | 2024-25 Q1 Plan | 2024-25 Q2 Plan | 2024-25 Q3 Plan | 2024-25 Q4 Plan | | | |
| | Quarter (%) | 92.3% | 92.5% | 92.8% | 93.0% | | | Yes |
| | Numerator | 11,395 | 11,613 | 11,814 | 12,336 | | | Yes |
| | Denominator | 12,352 | 12,555 | 12,738 | 13,264 | | | |

## 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 | 665.1 | 616.9 | 414.5 | 376.4 | the local authority's target for admissions in 2023/24 was 642 per 100,000 of population aged 65+. The comparative position at the end of 2023/24 was 713 per 100,000. (pre-populated figures are incorrect for the numerator) | Other supported accommodation continues to be developed post LGR to support people in the most appropriate setting (supported Housing, Supported Living, Extra Care) Work with care providers to upskill residential care staff to support people a range of needs uincluding dementia. Reduced number of residential providers exiting the market. (not BCF funding) | Yes |
| | Numerator | 1,031 | 1,012 | 680 | 630 | | | Yes |
| | Denominator | 155,016 | 164,040 | 164,040 | 167,386 | | | |

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.

## Better Care Fund 2024-25 Update Template

**8. Confirmation of Planning Requirements**

Selected Health and Wellbeing Board: North Yorkshire

| | 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 | 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 | Complete: |
|---|---|---|---|---|---|---|---|---|---|
| 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*<br><br>Has the HWB approved the plan/delegated (in line with the Health and Wellbeing Board's formal governance arrangements) approval? **Paragraph 11 as stated in BCF Planning Requirements 2023-25*<br><br>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*<br><br>Have all elements of the Planning template been completed? *Paragraph 11* | Cover sheet<br><br>Cover sheet<br><br>Cover sheet<br><br>Cover sheet | Yes | | | | Yes |
| | 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?<br><br>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? | Cover sheet<br><br>Planning Requirements | Yes | | | | Yes |
| 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? | | Yes | | | | Yes |
| 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? | | Yes | | | | Yes |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 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? | | Yes | | | | Yes |

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| 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 | | Yes | | | | Yes |
| 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? | | Yes | | | | Yes |