Health and Wellbeing Board agenda supplement

Date: Thursday 15 December 2022

Time: 2.00 pm

Venue: The Oculus, Buckinghamshire Council, Gatehouse Road, Aylesbury HP19 8FF

If you would like to attend a meeting, but need extra help to do so, for example because of a disability, please contact us as early as possible, so that we can try to put the right support in place.

For further information please contact: Sally Taylor on 01296 531024, email democracy@buckinghamshire.gov.uk.

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Health & Wellbeing Board Buckinghamshire

Overview of Health & Care Integration Programme

Date: 15 December 2022

Author/Lead Contacts: Jo Baschnonga, Programme Director Health & Care Integration, Buckinghamshire Council & Buckinghamshire NHS Trust

Report Sponsor: Gillian Quinton, Corporate Director Adults and Health, Buckinghamshire Council

Consideration: ☒ **Information** ☒ **Discussion**

☐ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Joint Local Health and Wellbeing Strategy, Happier, Healthier Lives Strategy (2022-2025) your report links to.

Start Well	Live Well	Age Well
☐ Improving outcomes during maternity and early years	☐ Reducing the rates of cardiovascular disease	☒ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☐ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☐ Increasing the physical activity of older people

None of the above? Please clarify below:

N/A

1. Purpose of report

To update on the Health and Care Integration Programme – including scope, deliverables, timescales, who is involved and what benefits patients can expect.

2. Recommendation to the Health and Wellbeing Board

No recommendation; report for awareness and discussion.

3. Content of report

3.1 Introduction

The flow of patients through health and care systems is critical to the quality of care received, and the effective management of capacity and resources. In line with the national average, around 70% A&E patients in Buckinghamshire are admitted, transferred or discharged within 4 hours (against a target of 95%). Nationally, this target was last met in 2015. Although this is a crude indicator, it gives a sense of the deeper challenges in moving patients onto hospital wards and through to the point of discharge.

From a patient perspective this can be critical - particularly for older frail patients. It is often said that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs (in people over 80 years old). We also know that frail elderly patients are more likely to need long-term bedded care after a period of deconditioning in hospital. For staff, poor patient flow creates pressure across the system, which can impact on working relationships and staff wellbeing.

During the Covid pandemic, optimising flow through health and care systems became even more critical in order to reduce risk of infection and enable systems to manage the unprecedented demand. Nationally, a model called 'discharge to assess' (D2A) was mandated (with a funding stream) to enable systems to move patients out of hospital quickly where they required social care support to return home. In Buckinghamshire, like many other places, this funding was invested in additional temporary bedded and home care. This additional D2A capacity enabled patients to be moved out of hospital while their social work and continuing health care assessments took place to determine their onward care provision. At the peak of the pandemic there were 180 D2A beds (spread across care homes in Buckinghamshire), and 11,000 hours of temporary home care.

Patient flow through the system today can be slow – particularly through our D2A bedded pathway. Here, the average length of stay in a D2A bed is 85 days. The average length of time spent receiving D2A temporary home care is 45 days. The reasons for this are complex – a high-level summary is provided in Appendix A. The impacts are significant - contributing to high numbers of patients waiting to be discharged ('medically optimised for discharge' - often exceeding 100 across the acute hospitals). The resulting pressure on hospital beds can result in patients not receiving the care they require and in some cases residing on trolleys for long periods (rather than in beds on wards). This also has the consequence of delaying ambulances whilst offloading at the hospital, with the corresponding pressures on how quickly they can respond to 999 calls.

Buckinghamshire is gripping the challenges around patient flow through a new programme of work called the Health & Care Integration Programme. This programme is currently focused on implementing a new hospital discharge model for the county, to reduce the length of time patients wait to be discharged. Alongside this, the Urgent & Emergency Care Transformation Programme at BHT is focused on improving flow through the hospital, including how alternative pathways to admission can help reduce the number of people having to attend hospital unnecessarily.

3.2 Who is involved?

The new integration programme is managed by a team of three staff, including a Programme Director, seconded from the partnership organisations and reports into the Integrated Care Partnership Executive Board (Chief Executives of the partner organisations). The Corporate Director for Adults and Health at Buckinghamshire Council, Chief Operating Officer at Buckinghamshire Healthcare NHS Trust, and the Place Director at Buckinghamshire Integrated Care Board provide senior leadership to the programme. A core group of operational staff from across the system are involved in designing the future model for the County, further engagement with a wider group of staff, patients, carers and the Voluntary and Charity Sector will happen in the first quarter of 2023. The programme comprises of ten workstreams – five delivering long term transformation, four 'enabler' workstreams which provide support to the programme (functions like HR and IT), and an 'operational control' workstream which aims to grip current operational challenges and deliver improvement in the short to medium term.

3.3 Health & Care Integration Programme - ambition

Our programme vision is:

'Working together to keep the people of Buckinghamshire healthy, and ensure safe and timely discharge from hospital – wherever possible back to their home'

Our objectives are to improve patient outcomes and value for money by

- Collaboratively driving better flow through the system
- Reducing the length of time Buckinghamshire residents wait to be discharged from hospital

Our programme principles are outlined below, they reflect the way we have agreed to work in partnership with each-other across organisational boundaries. Relationships and behaviours are crucial to driving action and achieving our objectives in such a complex partnership environment.

- Open, honest communication
- Strong collaboration & focus on people – design things together, regular communication, support each other
- Evidence-based, what works, pragmatic
- Pace
- Customer-focus

3.4 Scope of programme, deliverables and timescales

The expansion of D2A during the Covid pandemic was not expected to be a long-term sustainable position. The retraction of national D2A funding earlier this year has sharpened our focus on moving away from this model, which is not working well for Buckinghamshire residents in its current configuration.

3.5 D2A beds and assessments

Earlier in the year the Integrated Care Partnership (ICP) Executive Board made the decision to start decommissioning the County's D2A bedded capacity (at that point in time approximately 140 care home beds spread across Buckinghamshire). Importantly, this process was not intended to remove capacity from the system, rather enable the care home beds to be used differently (to support long-term care), and address the long length-of-stay in this pathway that was impacting on patient outcomes. During the initial phase of the integration programme over Summer, the number of D2A beds was almost halved (from 140 to 70 beds), while the flow through temporary home care was steadily improved.

We are now seeking to decommission all but 20 of our remaining D2A beds and return to a model where the majority of social work assessments (for ongoing care after leaving hospital) happen within the hospital setting (see key deliverables 1 and 2 below). This reflects the level of risk for patients currently within the D2A bedded pathway (with long average stays), and the cost which is no longer supported by a national funding stream. D2A beds will be decommissioned on a gradual trajectory ending in March 23, and a risk-based approach will be used to manage the transition of assessments from the community to the hospital, ensuring clinical risk to patients is minimised. It should be noted that approximately 50 Community Hospital Beds are available in the County to support rehabilitation and timely discharge (an increase from approximately 30 in Spring), and an additional 22 beds in community surge capacity to help manage demand over winter.

The remaining 20 D2A beds will include an appropriate rehabilitation offer, and will form part of Buckinghamshire's short-term post-discharge support offer. We are codesigning a new medium-term operating model with staff and patients to deliver this (to include a transition plan and system performance framework for all partners to sign up to).

3.6 Transformational deliverables

Deliverables 3-6 below refer to longer term transformational outputs which will deliver a more integrated approach to managing patient flow, supporting a further reduction in delays, improved patient outcomes, and better value for money.

In summary, the key deliverables of the programme, with timescales, are:

1. Reducing D2A beds to 20 (with appropriate rehabilitation offer) – end of March 2023
2. Transitioning majority of social care assessments into hospital (from community D2A pathways) – planning in progress, current expectation from April 2023
3. Implementing a transfer of care hub (an integrated team with clinicians, therapists, social workers, and case managers working together to plan discharge effectively and manage the patient journey end-to-end) – indicative timescale to be delivered summer 2023
4. Implementing an integrated digital offer (including a shared system to manage and track the flow of patients through the system) – phase 1 in Quarter 1-2 2023

5. A business case for our future intermediate care offer (which will provide the right type of temporary post-discharge support to re-able patients and determine any onward care quickly, so that they can return home as soon as possible, or to the setting that best meets their needs) – delivery to be decided (workstream being rescoped as a result of decisions made at October Executive Board)
6. Trusted Assessor (implementing a new model for assessing patients that increases assessment capacity and improves efficiency through building trust in the assessment process / quality) – from January 2023, pending agreement of business case in December 2022

3.7 What are the benefits for patients?

Ultimately, the programme is aiming to get patients home (or to the setting best suited to their needs) as soon as possible once they are medically fit to leave hospital. Prior to going home, we are aiming to ensure patients have the smoothest journey possible through the health and care system, with the fewest possible hand-offs and touch points. This should result in the best patient experience, improved staff experience and the best use of health and care resources.

In summary patients can expect:

- An improved journey leaving hospital with fewer hand-offs
- Less time in hospital and therefore less time away from their own bed
- Reduced likelihood of deconditioning, infection, confusion/disorientation, institutionalisation or increased dependence
- A named worker for discharge planning for every patient
- A person-focused approach to intermediate care which enables independence

4. Next steps and review

- To update on progress at the next Health and Wellbeing Board

5. Background papers

None

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Health & Wellbeing Board Buckinghamshire

Better Care Fund Plan 2022-2023

Date: **15 December 2022**

Author/Lead Contacts: Jo Baschnonga, Programme Director Health & Care Integration, Buckinghamshire Council & Buckinghamshire NHS Trust

Report Sponsor: Gillian Quinton, Corporate Director – Adults and Health, Buckinghamshire Council

Neil Macdonald, Chief Executive, Buckinghamshire Health Trust

Philippa Baker, Buckinghamshire Place Director, Buckinghamshire Oxfordshire and Berkshire West Integrated Care Board

Consideration: ☐**Information** ☐ **Discussion**

☒ **Decision** ☐ **Endorsement**

Please indicate to which priority in the Happier, Healthier Lives Strategy (2021-2024) your report links to.

Start Well	Live Well	Age Well
☐Improving outcomes during maternity and early years	☐ Reducing the rates of cardiovascular disease	☒ Improving places and helping communities to support healthy ageing
☐ Improving mental health support for children and young people	☐ Improving mental health support for adults particularly for those at greater risk of poor mental health	☒ Improving mental health support for older people and reducing feelings of social isolation
☐ Reducing the prevalence of obesity in children and young people	☐ Reducing the prevalence of obesity in adults	☒ Increasing the physical activity of older people

None of the above? Please clarify below:

N/A

1. Purpose of report

The Better Care Fund Adult Social Care Discharge Fund (the 'Discharge Fund') was announced in September to support the discharge of patients from hospital over the Winter period. The £500 million

national fund has been allocated and pooled locally into Better Care Fund (BCF) plans and Section 75 agreements. The total allocation for Buckinghamshire is £3.8m (with a 36%:64% split between the Council and the Integrated Care Board (ICB)). This paper presents a proposal for how the fund should be spent, which has been developed by the partnership through the Health and Care Integration Programme Board, and agreed by the Chief Executive Buckinghamshire Council, Chief Executive Buckinghamshire NHS Trust (BHT), and Place Director Integrated Care Board. In line with the BCF this jointly agreed plan should be signed off by the Health and Wellbeing Board (HWB). Each HWB area is required to submit their discharge fund plan to NHS England for assurance on 16th December 2022. Release of the first tranche of funds for December is contingent on an approved plan being submitted on this date.

2. Recommendation to the Health and Wellbeing Board

1. To approve the National Discharge Fund Plan for 2022-2023.
2. To delegate authority for oversight of Discharge Fund plans and expenditure to the Health & Care Integration Programme Board.

3. Content of report

3.1 Background

The purpose of the Discharge Fund is to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital, and must be spent by the end of this financial year. It recognises the national challenges around timely discharge, and the impact these can have on patients and systems during the pressurised Winter period.

This is a new fund for 22-23, but similar funds have operated in previous years in response to these challenges. Funding will be allocated in 2 tranches; the first tranche (40% of the total allocation) will be in December and the second tranche (60% of the total allocation) in January.

The Health and Care Integration Programme Board was set-up earlier this year to oversee Buckinghamshire's Integration Programme (which is designing a new hospital discharge and intermediate care model for the County), and is therefore well placed to provide joint accountability and oversight of the strategic direction, spend and performance of the Discharge Fund.

3.2 BCF Planning Requirements

The Discharge Fund submission must include a completed template detailing proposed expenditure (see Appendix 1). The conditions of the Fund are:

a) Funding should prioritise those approaches that are most effective in freeing up the maximum number of hospital beds within the funding available.
b) Funds should be spent by the end of March 2023.
c) Funding allocated to ICBs should be pooled into section 75 agreements.
d) ICBs should ensure that support from the NHS for discharges into social care is available throughout the week, including at weekends.

e) ICBs, hospital trusts and local authorities should work together to improve all existing NHSE and local authority discharge data collections.
f) Social care providers must keep the required capacity tracker data updated in line with the Adult Social Care Provider Provisions.
g) If the local authority fails to comply with any of these conditions, or if any overpayment is made under this grant, or any amount is paid in error, the Secretary of State may reduce, suspend, or withhold grant payments or require the repayment of the whole or any part of the grant monies paid, as may be determined by the Secretary of State, and notified in writing to the local authority.

The planned activity must support improvement to the following discharge metrics:

a) The number of care packages purchased for care homes, domiciliary care and intermediate care (to be collected via a new template);
b) The number of people discharged to their usual place of residence (existing BCF metric);
c) The absolute number of people 'not meeting criteria to reside' (and who have not been discharged);
d) The number of 'Bed days lost' to delayed discharge by trust (from the weekly acute sitrep); and
e) The proportion (%) of the bed base occupied by patients who do not meet the criteria to reside, by trust.

3.4 Discharge Fund allocation and priorities

Funding Route		**£000**
Via LA	**Buckinghamshire Council**	**1,393**
Via ICB	**Buckinghamshire**	**2,398**
TOTAL		**3,791**

This paper presents planned spend for the total pot of £3.791m. Appendix 1 contains the draft template for return to the national team. The template aligns the Discharge Fund plans with pre-existing BCF schemes. In summary, the plans are focused on the following schemes:

a) Local recruitment initiatives – including additional care finding capacity and dementia/ delirium specialist Nurses, Trusted Assessors (£487k)
b) Additional or redeployed capacity from current care workers – including additional social work capacity and redeployment to support discharge (£391k)
c) Home or Domiciliary Care – additional/ higher value care packages to manage Winter demand (£2.9m)
d) Administration – including business support to enable higher Care Finding throughput (£17k)

The Council and ICB will co-fund the plans for each of these schemes in line with the proportional allocation of the total fund (36% Council; 64% ICB), this is reflected in the split presented in the Appendix.

3.5 Consultation and Communication

The draft plan has been shared with the following colleagues across the partnership:

- Briefing for Cabinet Member for Health and Wellbeing and Director of Adult Social Services (DASS) Buckinghamshire Council (BC) 28th November 2022
- Health & Care Integration Programme Board 29th November 2022 - BC Service Director Integrated Commissioning; BC Service Director Adult Social Care Operations; BC Service Director Quality, Standards and Performance; BHT Director Community Transformation; ICB Place Director; DASS; BHT Chief Operating Officer; ICB Finance Place Lead;
- Shared for comments with BC Head of Finance, BHT Director Urgent & Emergency Care; Frimley ICB Integration Programme Director
- Integrated Commissioning Executive Team (ICET) Board 1st December 2022
- Integrated Care Partnership Executive Board 6th December 2022: BC Chief Executive; BHT Chief Executive; ICB Chief Operating Officer
- Health and Wellbeing Board 15th December 2022
- Final plan submission to NHS England 16th December 2022

4. Next steps and review

The agreed plan will be submitted to NHS England on 16th December. Two weekly reporting will commence from 30th December, as yet it is not clear what information will need to be included in these reports – guidance is expected imminently. Given this level of uncertainty it is possible that the template may need reframing.

If delegated responsibility is approved the Health & Care Integration Programme Board will monitor and oversee the Discharge Fund plan and expenditure through monthly meetings.

5. Background papers

Appendix 1 – Discharge Fund template

Discharge fund 2022-23 Funding Template

2. Cover

HM Government

Appendix 1

NHS

Version 1.0.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- This template has been produced for areas to confirm how the additional funding to support discharge from hospital and bolster the social care workforce will be spent in each area. The government has also produced guidance on the conditions attached to this funding, that you should ensure has been followed.

- This template collects detailed data on how the funding allocated to each area will be spent. The portion of the funding that is allocated via Integrated Care Boards (ICBs) does not have a centrally set distribution to individual HWBs. ICBs should agree with local authority partners how this funding will be distributed and confirm this distribution in a separate template. The amount pooled into the BCF plan for this HWB from each ICB should also be entered in the expenditure worksheet of this template (cell N31) (The use of all funding should be agreed in each HWB area between health and social care partners.

Health and Wellbeing Board:	Buckinghamshire
Completed by:	Colette Kavanagh
E-mail:	colette.kavanagh@buckinghamshire.gov.uk
Contact number:	01296 387428

Please confirm that the planned use of the funding has been agreed between the local authority and the ICB and indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Confirm that use of the funding has been agreed (Yes/No)	
Job Title:	Buckinghamshire Council Chief Executive; Integrated Care Board E
Name:	Rachael Shimmin; Steve McManus

If the following contacts have changed since your main BCF plan was submitted, please update the details.

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Angela	Macpherson	angela.macpherson@buckinghamshire.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Steve	McManus	steve.mcmanus4@nhs.net
	Local Authority Chief Executive		Rachael	Shimmin	rachael.shimmin@buckinghamshire.gov.uk
	LA Section 151 Officer		David	Skinner	david.skinner@buckinghamshire.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

When all yellow sections have been completed, 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.

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Discharge fund 2022-23 Funding Template

5. Expenditure

Selected Health and Wellbeing Board: Buckinghamshire

Source of funding		Amount pooled	Planned spend
LA allocation		*£1,392,765*	£1,392,765
ICB allocation			
	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	*2,398,000*	

Yellow sections indicate required input

Scheme ID	Scheme Name	Brief Description of Scheme (including impact on reducing delayed discharges).	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Estimated number of packages/beneficiaries	Setting	Spend Area	Commissioner	Source of Funding	Planned Expenditure (£)
1	Admiral Nurses	Recruitment of new Admiral Nurses to specifically work with supporting discharge	Local recruitment initiatives				Both	Community Health	Buckinghamshire	Local authority grant	£55,112
2	Admiral Nurses	Recruitment of new Admiral Nurses to specifically work with supporting discharge	Local recruitment initiatives				Both	Community Health	Buckinghamshire	ICB allocation	£94,888
3	Additional Social Worker capacity	Additional capacity for assessments to be undertaken during Winter	Additional or redeployed capacity from current care workers	Redeploy other local authority staff			Both	Social Care	Buckinghamshire	Local authority grant	£73,482
4	Additional Social Worker capacity	Additional capacity for assessments to be undertaken during Winter	Additional or redeployed capacity from current care workers	Redeploy other local authority staff			Both	Social Care	Buckinghamshire	ICB allocation	£126,518
5	Service Finding-Additional support	Additional support for finding service to facilitate timely discharge in the	Local recruitment initiatives				Both	Social Care	Buckinghamshire	Local authority grant	£48,866
6	Service Finding Additional support	Additional support for finding service to facilitate timely discharge in the	Local recruitment initiatives				Both	Social Care	Buckinghamshire	ICB allocation	£84,134
7	Care packages	Additional Long Term care packages linked to faster hospital discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		180		Social Care	Buckinghamshire	Local authority grant	£1,063,777
8	Trusted Assessor	Trusted assessor initiative and recruitment of 2 Trusted Assessors	Local recruitment initiatives				Both	Community Health	Buckinghamshire	Local authority grant	£45,559

9	Trusted Assessor	Trusted assessor initiative and recruitment of 2 Trusted Assessors	Local recruitment initiatives				Both	Community Health	Buckinghamshire	ICB allocation	£78,441
10	Additional staff to support with winter/hospital	Redeploy current Local Authority staff to support with hospital discharge over	Additional or redeployed capacity from current care workers	Redeploy other local authority staff			Both	Social Care	Buckinghamshire	Local authority grant	£51,437
11	Additional staff to support with winter/hospital	Redeploy current Local Authority staff to support with hospital discharge over	Additional or redeployed capacity from current care workers	Redeploy other local authority staff			Both	Social Care	Buckinghamshire	ICB allocation	£88,563
12	Service Finding for health funded packages of care	Service finding resource for ad hoc health funded packages and admission	Local recruitment initiatives				Both	Community Health	Buckinghamshire	Local authority grant	£20,208
13	Service Finding for health funded packages of care	Service finding resource for ad hoc health funded packages and admission	Local recruitment initiatives				Both	Community Health	Buckinghamshire	ICB allocation	£34,792
14	Discharge co-ordinator	System Discharge co-ordinator to problem solve and improve flow across the	Local recruitment initiatives				Both	Community Health	Buckinghamshire	Local authority grant	£9,185
15	Discharge co-ordinator	System Discharge co-ordinator to problem solve and improve flow across the	Local recruitment initiatives				Both	Community Health	Buckinghamshire	ICB allocation	£15,815
16	Administration costs	Administration costs	Administration				Both	Social Care	Buckinghamshire	Local authority grant	£6,246
17	Administration costs	Administration costs	Administration				Both	Social Care	Buckinghamshire	ICB allocation	£10,754
18	Discharge to Assess (D2A)	To support hospital flow via the D2A Home First pathway	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		425	Both	Community Health	Buckinghamshire	ICB allocation	£1,831,563
19	Digital	Additional workforce to optimise the use of digital to improve flow	Additional or redeployed capacity from current care workers	Redeploy other local authority staff			Both	Community Health	Buckinghamshire	Local authority grant	£18,894
20	Digital	Additional workforce to optimise the use of digital to improve flow	Additional or redeployed capacity from current care workers	Redeploy other local authority staff			Both	Community Health	Buckinghamshire	ICB allocation	£32,531

Scheme types and guidance

This guidance should be read alongside the addendum to the 2022-23 BCF Policy Framework and Planning Requirements.

The scheme types below are based on the BCF scheme types in main BCF plans, but have been amended to reflect the scope of the funding. Additional scheme types have been added that relate to activity to retain or recruit social care workforce. The most appropriate description should be chosen for each scheme. There is an option to select 'other' as a main scheme type. That option should only be used when none of the specific categories are appropriate.

The conditions for use of the funding (as set out in the addendum to the 2022-23 BCF Policy Framework and Planning Requirements) confirm expectations for use of this funding. Funding should be pooled into local BCF agreements as an addition to existing section 75 arrangements. Local areas should ensure that there is agreement between ICBs and local government on the planned spend.

The relevant Area of Spend (Social Care/Primary Care/Community Health/Mental Health/Acute Care) should be selected

The expenditure sheet can be used to indicate whether spending is commissioned by the local authority or the ICB.

This funding is being allocated via:
- a grant to local government - (40% of the fund)
- an allocation to ICBs - (60% of the fund)

Both elements of funding should be pooled into local BCF section 75 agreements.

Once the HWB is selected on the cover sheet, the local authority allocation will pre populate on the expenditure sheet. The names of all ICBs that contribute to the HWB's BCF pool will also appear on the expenditure sheet. The amount that each ICB will pool into each HWB's BCF must be specified. ICBs are required to submit a separate template that confirms the distribution of the funding across HWBs in their system. (Template to be circulated separately).

When completing the expenditure plan, the two elements of funding that is being used for each line of spend, should be selected. The funding will be paid in two tranches, with the second tranche dependent on an area submitting a spending plan 4 weeks after allocation of funding. The plan should cover expected use of both tranches of funding. Further reporting is also expected, and this should detail the actual spend over the duration of the fund. (An amended reporting template for fortnightly basis and end of year reporting, will be circulated separately)

Local areas may use up to 1% of their total allocation (LA and ICB) for reasonable administrative costs associated with distributing and reporting on this funding.

For the scheme types listed below, the number of people that will benefit from the increased capacity should be indicated - for example where additional domiciliary care is being purchased with part of the funding, it should be indicated how many more packages of care are expected to be purchased with this funding.

Assistive Technologies and Equipment
Home Care or Domiciliary Care
Bed Based Intermediate Care Services
Reablement in a Person's Own Home
Residential Placements

Scheme types/services	**Sub type**	Notes	home care?
Assistive Technologies and Equipment	1. Telecare 2. Community based equipment 3. Other	You should include an expected number of beneficiaries for expenditure under this category	Y
Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge 3. Domiciliary care workforce development 4. Other	You should include an expected number of beneficiaries for expenditure under this category	Y
Bed Based Intermediate Care Services	1. Step down (discharge to assess pathway 2) 2. Other	You should include an expected number of beneficiaries for expenditure under this category	N
Reablement in a Person's Own Home	1. Reablement to support to discharge – step down 2. Reablement service accepting community and discharge 3. Other	You should include an expected number of beneficiaries for expenditure under this category	Y
Residential Placements	1. Care home 2. Nursing home 3. Discharge from hospital (with reablement) to long term care 4. Other	You should include an expected number of beneficiaries for expenditure under this category	N
Increase hours worked by existing workforce	1. Childcare costs 2. Overtime for existing staff.	You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
Improve retention of existing workforce	1. Retention bonuses for existing care staff 2. Incentive payments 3. Wellbeing measures 4. Bringing forward planned pay increases	You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
Additional or redeployed capacity from current care workers	1. Costs of agency staff 2. Local staff banks 3. Redeploy other local authority staff	You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
Local recruitment initiatives		You should indicate whether spend for this category is supporting the workforce in: - Home care - Residential care - Both	Area to indicate setting
Other		You should minimise spend under this category and use the standard scheme types wherever possible.	Area to indicate setting
Administration		Areas can use up to 1% of their spend to cover the costs of administering this funding. This must reflect actual costs and be no more than 1% of the total amount that is pooled in each HWB area	NA

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