Norfolk County Council

Cabinet

Date: **Monday 4 December 2023**

Time: **10 am**

Venue: **Council Chamber, County Hall, Martineau Lane, Norwich NR1 2DH**

SUPPLEMENTARY
A g e n d a

Advice for members of the public:

This meeting will be held in public and in person.

It will be live streamed on YouTube and members of the public may watch remotely by clicking on the following link: Norfolk County Council YouTube

We also welcome attendance in person, but public seating is limited, so if you wish to attend please indicate in advance by emailing committees@norfolk.gov.uk

Current practice for respiratory infections requests that we still ask everyone attending to maintain good hand and respiratory hygiene and, at times of high prevalence and in busy areas, please consider wearing a face covering.

Please stay at home if you are unwell, have tested positive for COVID-19, have symptoms of a respiratory infection or if you are a close contact of a positive COVID-19 case. This will help make the event safe for attendees and limit the transmission of respiratory infections including COVID-19.

12 Better Care Fund 2023/24:

- **Appendix A:** BCF approval Letter **(Page B3)**
- **Appendix B:** BCF narrative, 2023-25 **(Page B7)**
- **Appendix C:** Updated Norfolk BCF plan, 2023-25 **(Page B44)**

A report by the Interim Executive Director of Adult Social Services

Tom McCabe
Chief Executive
County Hall
Martineau Lane

Norwich
NR1 2DH

Date Supplementary Agenda Published: 1 December 2023

IN TRAN communication for all	**If you need this document in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.**

NHS England
Wellington House
133-155 Waterloo Road
London,
SE1 8UG
E-mail:
england.bettercarefundteam@nhs.net

To: *(by email)*
Cllr Bill Borrett, Chair, Norfolk Health and Wellbeing Board
Tracey Bleakley, Integrated Care Board Chief Executive or Representative(s)
Tom McCabe, Chief Executive, Norfolk County Council

03 October 2023

Dear Colleagues,

BETTER CARE FUND 2023-25

Thank you for submitting your Better Care Fund ("**BCF**") plan for regional assurance and approval. I am pleased to let you know that following this process, your plan has been classified as '**approved**'. You should now proceed to finalise your section 75 agreements with a view to these being signed off by 31 October 2023.

We are grateful for your commitment to developing and producing your agreed plan and we recognise that there are many pressures on local system colleagues, despite the early publication of the planning requirements.

The BCF is the only mandatory policy to facilitate the integration of health, social care and housing funding. This is the second time that the BCF Policy Framework covers two financial years to align with NHS planning timetables and to give areas

the opportunity to plan more strategically.

BCF Conditions for financial year 2023/4

The BCF funding from NHS England for the financial year 2023/24, which includes additional discharge funding, can now be formally released subject to compliance with the following conditions (referred to as "the **BCF Conditions**"):

- The BCF funding is used in accordance with your final approved plan.
- The national conditions ("the **National Conditions**") set out in the BCF Policy Framework for 2023-25 and further detailed in the BCF Planning Requirements for 2023-25 continue to be met.
- Satisfactory progress is made towards meeting the performance objectives specified in your BCF plan.
- Reports on your area's progress and performance are provided to NHS England in accordance with relevant guidance and any requests made by NHS England and governmental departments. This includes quarterly reporting on the BCF overall and fortnightly reporting on use of the Additional Discharge Funding, as set out in the Planning Requirements document.

Escalation

The BCF Conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006. This means that if the BCF Conditions are not complied with NHS England can, under section 223GA:

- withhold any payment, if any of the BCF Funding has not already been made available to the ICB;
- recover any of the funding (either from the current financial year or a subsequent financial year); and/or
- direct the ICB or ICBs in your Health and Wellbeing Board area as to the use of the funding.

Where an area is not compliant with one or more BCF Conditions or there is a material risk that a BCF Condition will not be met, an area may enter into escalation, as outlined in the BCF Planning Requirements 2023-25. This could lead to NHS England exercising the powers outlined above. Any intervention will be proportionate to the risk or issue identified.

Local authority funding for financial year 2023/4

Grants to local government (improved Better Care Fund, Additional Discharge Fund

and Disabled Facilities Grant) will continue to be paid to local government under s31 of the Local Government Act 2003, via the Department of Levelling Up, Housing and Communities, with a condition that they are pooled into one or more pooled funds under section 75 of the NHS Act 2006 and spent in accordance with your approved BCF plan.

Reporting and compliance

Ongoing support and oversight regarding the spending of BCF funding will continue to be led by your local Better Care Manager ("**BCM**"). Following regional assurance, we are asking all BCMs to feed back to local systems where the process identified areas for improvement in plans, including where systems may benefit from conversations with other areas. Nationally, we will also be reflecting on the data and what further support we can consider in the future.

Reporting on the overall BCF programme for 2023-25 will resume in September with quarterly reporting and an end of year return. In preparation for winter and to ensure ongoing alignment with urgent and emergency care recovery plans, the Quarter 2 report will include a check that your Intermediate Care Capacity and Demand plans are still fit for purpose as we enter months where capacity is often stretched. Your refreshed Intermediate Care Capacity and Demand plan needs to be submitted by 31 October 2023. All templates and guidance will be published on the Better Care Exchange. Further information on quarterly and end of year reporting will be confirmed in due course.

You will be aware that there are additional reporting requirements for the Additional Discharge Fund. The Government maintains a strong interest in improving timely discharge of patients; details of additional reporting on this part of the fund have been published. NHS England also requires a monthly return on packages provided to date, spend to date and forecast spend data on an ICB footprint. There is a commitment to review these reporting arrangements for 2024-25.

BCF Conditions for financial year 2023/24

As explained above, the BCF Policy Framework covers the financial years 2023/24 and 2024/25. NHS England expects that before any BCF funding for 2024/25 is made available it will write to areas to notify them that the BCF Conditions for 2023/24 set out in this letter will also apply to 2024/25.

If your area is in breach of its BCF Conditions or there is a material risk that it will breach a BCF Condition, then further conditions may be applied to BCF funding for

2024/25.

Once again, thank you for your work and best wishes with implementation and ongoing delivery.

Yours sincerely,

Nicola Hunt

Senior Responsible Officer for the Better Care Fund
NHS England

Copy (by email) to:

Clare Panniker, Regional Director, NHS England
Rosie Seymour, Programme Director, Better Care Fund team, Better Care Fund Programme, NHS England
Isla Rowland, Better Care Manager, Better Care Fund Programme, NHS England

HM Government

NHS England

BCF Narrative Plan 2023-25

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (Excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate Excel planning template, a narrative plan covering more than one HWB can be submitted where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their Excel planning template.

Cover

Health and Wellbeing Board(s)
Norfolk

Which bodies have been involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)?

RESPONSE:

The key system groups and partners involved in preparing the BCF Plan for 2023-25, have included (but are not limited) to the following.

- Place Boards (which bring together the NHS, Local Authorities and VCSE organisations, residents, people who access services, carers and families. These partnerships lead the design and delivery of integrated services in their local area.)
- Health and Wellbeing Partnerships (which bring together colleagues from Local Authorities, health services, VCSE organisations and other system partner organisations)
- Local Authorities
    - Norfolk County Council (NCC)
    - City, Borough and District Councils
    - Engagement with Suffolk County Council as neighbouring Health and Wellbeing Board in our ICS footprint
- NHS Norfolk and Waveney Integrated Care Board (N&W NHS/NWICB)
- Acute hospitals
    - Norfolk and Norwich University Hospitals NHS Foundation Trust
    - Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
    - James Paget University Hospitals NHS Foundation Trust
- Community healthcare providers
    - Norfolk Community Heath and Care NHS Trust
    - East Coast Community Health CIC
- Mental health provider: Norfolk and Suffolk NHS Foundation Trust
- Primary Care, including
    - Primary Care Networks
    - General Practice partnership organisations
    - pharmacy system partners
- VCSE system partners
- Healthwatch Norfolk
- Norfolk Police and the Police and Crime Commissioner (PCC).

How have you gone about involving these stakeholders?

RESPONSE

System partners for Norfolk continue to work collaboratively with commissioners from the Local Authority and the ICB to ensure that all services and schemes, including the BCF schemes, deliver improved outcomes for our population.

The BCF model is acknowledged to be an important tool to support this joint working as it aims to increase prevention, address inequalities and support the needs of Place, in alignment with the Priorities set out by Norfolk's Health and Wellbeing Board (HWB) in 2021-22

The recent move to an Integrated Care System (ICS) has accelerated this joint working. The ICS introduced seven Health and Wellbeing Partnerships to Norfolk which were established as multi-agency groups and suitably positioned to understand the health and wellbeing needs of their local areas. Partnerships are chaired by District Councils and comprise a range of statutory and non-statutory providers working in each of the Council footprints. Alongside this, there are five new Place Boards, with bring together system partners to improve integration with a focus on effective operational delivery and improving people's experience of care. Engaging with these forums to discuss Place-based approaches has been enabling the Norfolk system to use the BCF to involve and empower NHS Trusts, social care providers, voluntary and community service partners and other system partners in the development of the BCF.

For example, the Health and Wellbeing Partnerships have been provided with a sum of money by the Local Authority, taken from the BCF, to fund prevention services in their area, particularly focusing on reducing care home admissions and admission to acute hospitals. This resulted in a wide range of local programmes emerging for the 2023/24 BCF plan, including

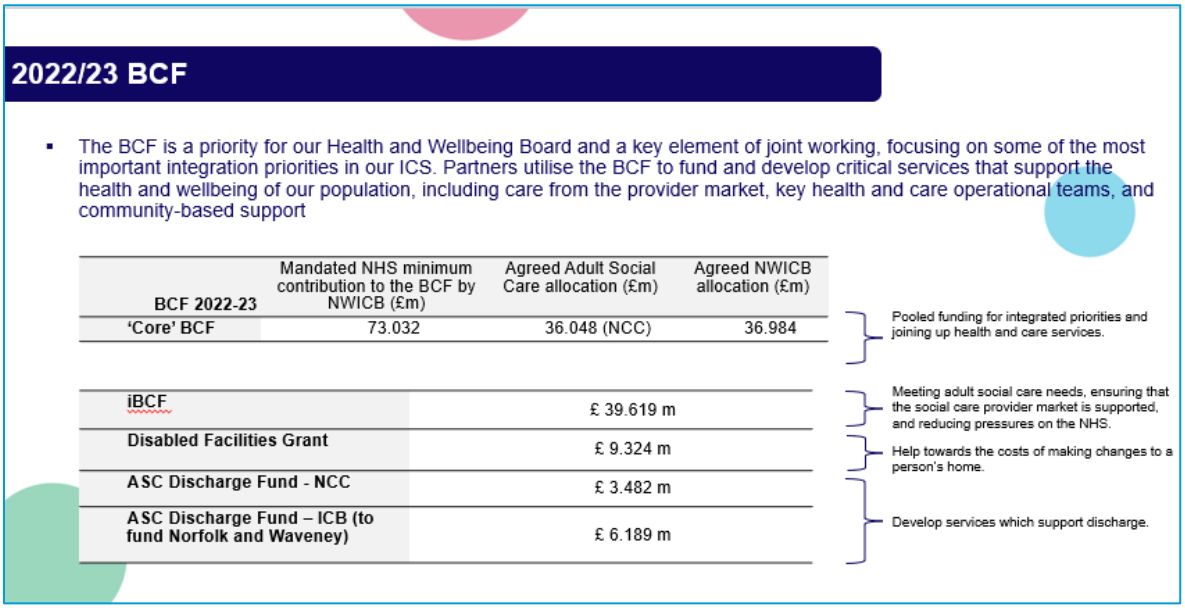
- a pilot offering social prescribing in secondary care outpatient services,
- an expansion of handy person and adaptation services focussed orthopaedic waiting lists to include those with rheumatology to prevent falls,
- a fund for agencies to innovate hardship support services,
- an expansion of an Age UK Community Support service to enable more people to benefit, and
- a new falls prevention initiative.

In addition, the different funding streams under the BCF have provided opportunities to bring system partners together to discuss spend and prioritise schemes.

- **Core BCF** - brings LAs and NHS partners together to agree integrated priorities, pool funding and jointly agree spending plans.
- **Disabled Facilities Grant (DFG)** – City, District and Borough Councils are specifically engaged and involved in developing priorities and plans for the Disabled Facilities Grant. They deliver the home adaptations and improvements so the person can continue to live in an environment that is suitable for their needs.

- **i-BCF** – is managed by Norfolk County Council as social care funds to meet adult social care needs, ensure that the social care provider market is supported and reduce pressures on the NHS.
- **Additional Discharge Fund (ADF)** – this new fund established in 2022-23 has enabled system partners to focus on schemes that improve and enhance support for discharges, such as care market commissioning and Place-based commissioning of bed-based rehabilitation offers.

At a more granular level, the recent introduction of the BCF Capacity and Demand Plan and the Additional Discharge Fund has necessitated close working with system colleagues to collate the necessary data and make quick decisions about how best to allocate funding.



2022/23 BCF

- The BCF is a priority for our Health and Wellbeing Board and a key element of joint working, focusing on some of the most important integration priorities in our ICS. Partners utilise the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community-based support

BCF 2022-23	Mandated NHS minimum contribution to the BCF by NWICB (£m)	Agreed Adult Social Care allocation (£m)	Agreed NWICB allocation (£m)	
'Core' BCF	73.032	36.048 (NCC)	36.984	Pooled funding for integrated priorities and joining up health and care services.
iBCF		£ 39.619 m		Meeting adult social care needs, ensuring that the social care provider market is supported, and reducing pressures on the NHS.
Disabled Facilities Grant		£ 9.324 m		Help towards the costs of making changes to a person's home.
ASC Discharge Fund - NCC		£ 3.482 m		Develop services which support discharge.
ASC Discharge Fund – ICB (to fund Norfolk and Waveney)		£ 6.189 m		

There is a Social Care and Health Partnerships Team jointly (ICB:LA) funded via the BCF which attends a range of meetings across each year to talk about the BCF and increase awareness of how it is used in Norfolk. For example, in recent months there have been meetings to discuss the BCF schemes from the BCF Plans for Norfolk and for Suffolk which are delivered in the East Locality (which covers East Norfolk and the Waveney area of north Suffolk), with colleagues from this jointly funded team and from Norfolk County Council, Suffolk County Council and NWICB.

The ambition is to further align the Core BCF with Place over the next few years, whilst balancing that with system-wide schemes which provide best value for money when delivered as pan-Norfolk services, for example the Integrated Community Equipment Service (ICES).

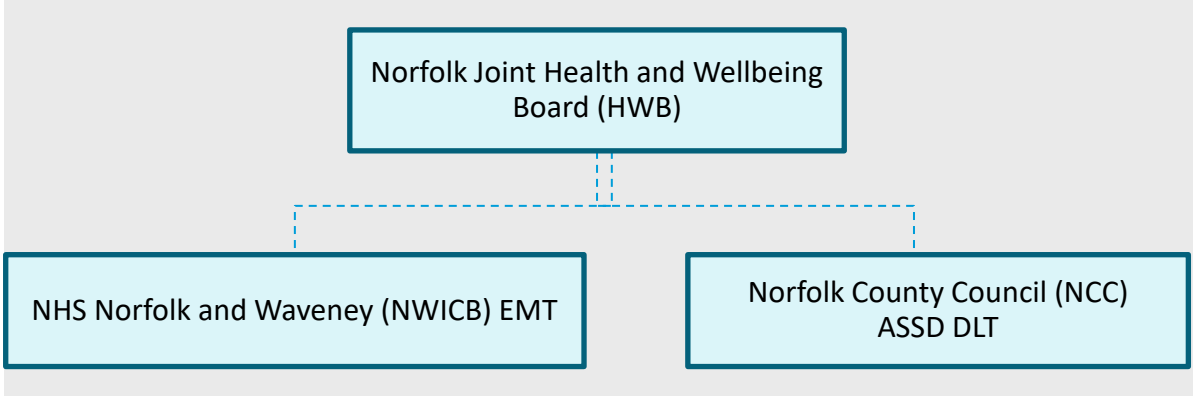
Governance

Please briefly outline the governance for the BCF Plan and its implementation in your area.

RESPONSE

As required as a statutory duty, the Better Care Fund (BCF) is governed by the Norfolk Joint Health and Wellbeing Board (HWB), who agree the approach to the BCF and sign off plans and submissions.

NHS Norfolk and Waveney (NWICB) Executive Management Team (EMT) and the Norfolk County Council (NCC) Adult Social Services Directorate (ASSD) Leadership Team (DLT) form the governance route in to the HWB Board as set out in the diagram below. Represented in these groups are the ICB's Chief Executive Officer, Tracey Bleakley, and the Director of Adult Social Services, Debbie Bartlett.



A Joint Social Care and Health Assurance Board has also been established which increases the integrated governance for the BCF Plan. This Assurance Board reports to the ICB's Executive Management Team, the NCC Directorate Management Teams and Suffolk County Council (SCC) Directorate Management Teams, with a reporting line into the ICB's Transformation Board and the Integrated Care Partnership (ICP). Membership from SCC ensures that the whole ICS footprint is represented, as the ICS contributes to two separate BCF plans (Norfolk and Suffolk).

The 22/23 End of Year report and the plan for 23/25 was presented at the HWB on the 20th of June 2023 and the recommendations to drive forward Norfolk's ambitions for the BCF were agreed.

This includes;

- A single BCF plan that combines system and Place ambitions and brings together teams and leaders who are delivering services and change that drive the BCF priorities.
- Development of Norfolk's BCF approach, including: metrics of success/outcomes for all BCF funded services, not just the five overarching national metrics; and a county-wide 'demand and capacity plan' for discharge and community support
- Increasingly align the BCF with new ICS Places, supporting local joint health and care working. This includes collaborative proposals from Health and Wellbeing Partnerships with funding through the annual BCF uplift to support localised delivery of the BCF.

The HWB Board are keen to understand the impact of our services and are supportive of planned work to look at KPIs and beneficiaries.

In Spring 2023, a summary paper about the BCF was presented to the ICB's EMT by the ICB's commissioning lead for the BCF (Associate Director for Community Commissioning).

An in-year review of the Core BCF schemes for Norfolk and for the Waveney area of Suffolk (i.e., the whole ICS footprint) is supported by the ICB Finance committee. More information on the proposed review can be found in National Condition 1 later in this paper. The Finance Committee is coordinated by the ICB and comprises system partner stakeholders from the acute hospitals, VCSE sector, the Local Authority and community providers.

Executive Summary

This should include

- Priorities for 2023-25
- Key changes since the previous BCF Plan

Partners in Norfolk have long utilised the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community-based support from the VCSE sector

In 2022/23 a new Intermediate Capacity and Demand Plan was introduced into the Better Care Fund, looking at intermediate care covering both admissions avoidance and hospital discharge across health and social care. For 2023-25, this has been embedded in the financial and metrics return, and now specifically also includes our mental health services. The plan will be developed in alignment with our wider planning and delivery for capacity and demand, alongside Urgent and Emergency Care plans.

Overall, for 2023-25, the core elements of the BCF planning requirements remain consistent with an aim to continue strengthening the integration of commissioning and delivery of services, as well as continuing to provide person-centred care. The increased focus on the two new National Conditions strengthens focus on person centred outcomes, and reflect our system wide ambitions, to make sure everyone can live as healthy a life as possible.

Norfolk is committed to integrated working and joint commissioning across the health and social care system. This is reflected in the governance routes outlined above and the number of jointly funded and multi-agency, multi-disciplinary teams in the system.

The Additional Discharge Fund (ADF), launched in 2022 as the Adult Social Care (ASC) Discharge Fund, has had a significant impact on integrated working. This new source of funding has enabled system partners to co-develop innovative new schemes to address some of the long-standing issues with supported discharges to home. The recurrency of this funding has helped us to build a programme where the services being funded support intermediate care and the HomeFirst approach. It has been instrumental in delivering additional capacity to support people home following crisis.

We have committed to carrying out a review of schemes in this financial year and to better understand the impact of schemes across the system. The findings will influence our future investments decisions enabling the system to focus on those schemes that provide best value and meet the aims of the BCF and wider ICS.

National Condition 1: Overall BCF Plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are

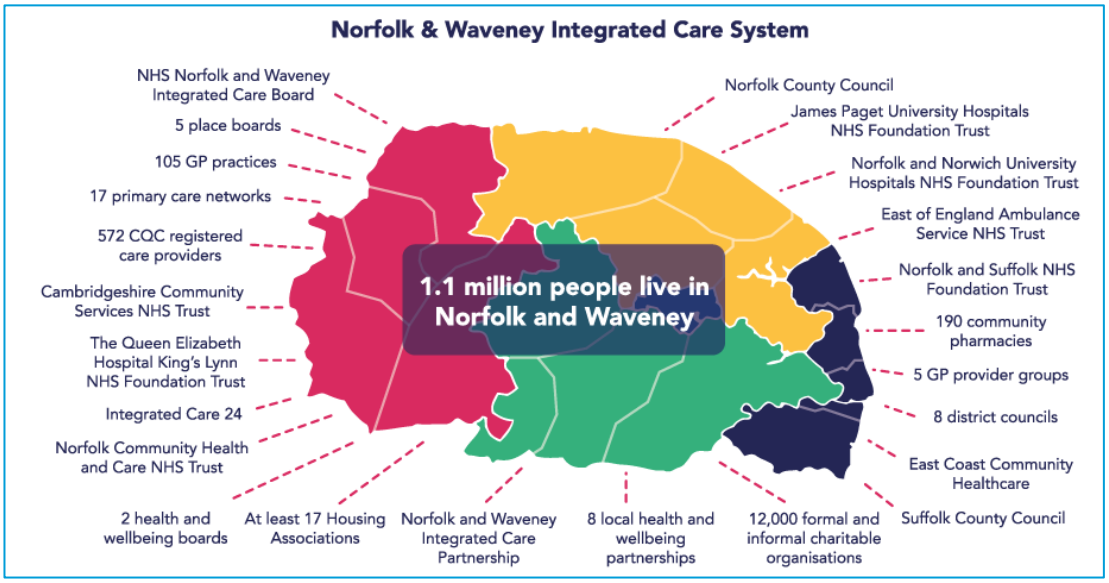
commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

(PR4 - A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home)

Please outline your approach to embedding integrated, person-centred health, social care and housing services

RESPONSE

The Norfolk & Waveney Integrated Care System (NWICS) was formed in July 2022. Its population is spread across a mixture of urban and inner city areas, some of which are recognised as being areas of high deprivation, as well as sparsely populated rural areas. The population in Norfolk and Waveney is generally older than the England population, with 1 in 4 being over 65. The population is expected to grow by about 116,500 people between 2020 and 2040. The largest growth is expected in the older age groups, with those aged 65+ increasing by 95,000. In addition, the needs of our population are becoming increasingly complex, so we must focus our services being accessible and effective for residents and their unpaid carers, whilst improving co-ordinating and integration make best use of our limited resources.



The Integrated Care Partnership is responsible for coordinating the development of an Integrated Care Strategy for Norfolk and Waveney. This document is the key strategy for the whole Integrated Care System and its partners. It sets out the challenges and opportunities to improving short- and long-term health and care outcomes.

The strategy was developed collaboratively and in November 2022 published the 'Transitional Integrated Care Strategy and Joint Health and Wellbeing Strategy' which stated that the overarching aim of the system is to "*help the people of Norfolk to lead longer, healthier and happier lives*".

This joint strategy introduced four system priorities, which are complementary to Norfolk's five BCF Priorities as agreed by the HWB in 2021.

NWICS Strategic Priorities	Norfolk BCF Priorities
1. Driving Integration	*[Overall purpose of the BCF]*
2. Prioritising Prevention	• Prevention, including admission avoidance • Person-centred care and discharge
3. Addressing Inequalities	• Inequalities and support for the wider factors of wellbeing • Housing, DFGs and overarching pieces of work.
4. Enabling Resilient Communities	• Sustainable systems

The priorities are being used to inform the development of the first five-year Joint Forward Plan (JFP), to be published at the end of June 2023. The JFP will set out how NWICS aims to overcome some of the immediate challenges in the system, as well as an improvement plan for the medium term.

A key strength of our system is that Local Authorities, voluntary and community organisations, NHS partners, providers, and most importantly the communities and people we provide services for, all have input. This includes ensuring that our strategies and plans work cohesively and collaboratively across the system, that we listen to the public and are transparent about our strategies across all organisations. A fundamental element of the new JFP are eight Ambitions, which have been collaboratively developed.

Each Ambition will be driven by its own work programme, coming together as a collective portfolio of change to enable the system to deliver the JFP and the system aim of "*helping the people of Norfolk to lead longer, healthier and happier lives*".

1. Mental Health Transformation
2. Urgent and Emergency Care Transformation
3. Elective Recovery and Improvement
4. Primary Care Resilience and Transformation
5. Improving Productivity and Efficiency
6. Population Health Management, Reducing Inequalities and Supporting Prevention
7. Babies, Children, Young People and Maternity
8. Older People.

We aim to work as a single sustainable system in the delivery of person-centred care across our complex organisational and service delivery landscape. Where possible we are shifting our focus and investment into community-based support, pooling resources and budgets (through Section 75 agreements) and building on priorities that system partners are already working hard to address.

Examples include

- Community Voices - we have been working with local communities to understand their experiences of health and care and ensure their voices are heard when planning and delivering services. Community Voices works with trusted local communicators to speak with communities who do not engage easily with local

health services including people affected by substance misuse and poor mental health. Listening to and learning from voices in these communities has helped system partners to develop targeted resources, such as online information and subject-specific webinars, with messaging built around the issues identified through the feedback. We have also been working with the University of East Anglia (UEA) to look at the best way to collect, store and use this anonymised, qualitative data as this will empower our system to move beyond information about treatment and services, to hear people's whole lived experience.

- Shared Care Record – our Shared Care Record is now live as a Proof of Principle, following successful system testing and will fully launch in Summer 2023. The Shared Care Record is improving the visibility of GP, community, social care, mental and acute patient records – reducing the need for our citizens to tell their story multiple times and avoiding duplication of activity.
- Digital Social Care Record – NWICS was awarded funding by NHS Transformation to support CQC Registered Care Providers in Norfolk with grants of up to 50% of the first-year implementation costs for moving from paper records to a Digital Social Care Record. Providers have access to an Assured Supplier list and other resources to support their decision making. This approach is supported by resources from the NW Digital Health & Social Care Team, NHSE, NWICB Shared Care Record Team, the CQC, Norfolk County Council and Norfolk & Suffolk Care Support. NWICS was the only ICS in England to get engagement and representation form CQC for this initiative.
- VCSE Assembly (established July 2022) – our system is focusing on preventative and early interventions for our citizens to help address their challenges, issues and needs before they escalate or result in a crisis. The VCSE sector are often ideally placed to support in this way and the VCSE Assembly has been brought together to coordinate this action for the system. Assembly member organisations have also committed to working together to address the known health and wellbeing inequalities in Norfolk and Waveney, including piloting new ways of working alongside statutory partners. The VCSE Assembly is intending to be a positive force for change, where collaboration gives measurable, tangible outputs and outcomes. The Assembly is a shared space, where any and every VCSE organisation can work with system partners from across the NWICS – at system, Locality, Place and Neighbourhood levels - to learn together and build shared approaches to deliver interventions that empower our citizens and communities.
- Inspiring Communities project - a partnership involving a Breckland district council, the NHS and charity partners has been supporting the health and wellbeing of residents by working together to tackle health inequalities in Breckland. They have supported some of the district's most vulnerable people, including those who have experienced domestic abuse, isolation or loneliness, and people in need of mental health support. The programme has helped hundreds of local people to access the care they need, while reducing demand on GPs and hospital services and making savings to the public purse. Breckland Council delivers a Social Prescribing service which sees Community Connectors spending time getting to know patients and listening to their whole story, before helping patients to access the care and support they need and feel empowered to work through their issues. In addition, Breckland Council and the NHS Norfolk and Waveney Integrated Care Board have implemented an innovative new Community Health Worker service, in collaboration with Watton Medical Practice.

Approaches to joint/collaborative commissioning

Norfolk is committed to integrated working and joint commissioning across the health and social care system. This is reflected in the governance routes outlined above and the number of jointly funded and multi-agency, multi-disciplinary teams in the system.

Within the Integrated Care System, the Integrated Care Partnership (ICP) plays a key role to promote the close collaboration of the health and care systems across Norfolk and Waveney – by bringing together health and social care providers, local government, the voluntary, community and social enterprise (VCSE) sector, and other partners.

It drives and enhances integrated approaches to address challenges that the health and care system cannot address alone. This includes prioritising prevention, reducing health inequalities and addressing the wider social and economic factors affecting our communities. The Health and Wellbeing Partnerships have developed their own local strategies which build on the ICS strategy published in November 2022

The Norfolk BCF is focused on schemes which are either

- jointly funded, and/or
- would benefit from strong integrated oversight, and/or
- are intended to deliver outcomes that will have a positive impact on the provision of health and social care in our system.

Many BCF schemes are jointly funded and commissioned by the Local Authority and the ICB, for example.

- A Social Impact Bond for Carers – supports carers with information, advice, support and Carers Assessments to improve their wellbeing and help them maintain their caring role.
- Norfolk Advice Network and Advocacy Partnership – provides a single point of contact for information, advice and advocacy in Norfolk.
- Norfolk First Support (NFS) Reablement Services – an essential service which provides urgent community response including responding to non-injurious fallers, reablement at home as a prevention/admission avoidance response to support individuals in crisis, and reablement at home to support discharge from hospital.
- District Direct – dedicated District Council resources which identify and overcome housing related barriers to discharge, working as part of the multi-agency, multi-disciplinary HomeFirst Hubs. The aim of the service is to enable residents to return home in a timely manner from hospital to an environment that meets their needs, with all necessary support in place. Whenever possible, potential issues with returning home post-discharge are flagged soon after admission to the District Direct team. These issues are resolved prior to the person being confirmed as ready for discharge with the intention of preventing any last-minute delays to discharge due to housing related issues.

How are BCF funded services supporting your approach to integration? Briefly describe any changes to the services you are commissioning through the BCF from 2023-25

As a system we are increasingly looking to develop place based working as a route to ensuring the right care in the right place. Funds have been delegated to the 7 Health and Wellbeing Partnerships (all aligned to district council footprints) to support local BCF priorities. It has also been agreed that DFG plans will be taken to those partnerships to offer greater transparency.

The Additional Discharge Fund (ADF), launched in 2022 as the Adult Social Care (ASC) Discharge Fund, has had a significant impact on integrated working. This new source of funding which has come via the BCF has enabled system partners to co-develop innovative new schemes to address some of the long-standing issues with supported discharges to home.

The Additional Discharge Fund is recurrent funding, over 2023-24 and 2024-25. The recurrency of this funding has helped us to build a programme where the services being funded support intermediate care and the HomeFirst approach. It has been instrumental in delivering additional capacity to support people home following crisis, including:

- Housing with Care Flats – 21 'Housing with Care' flats have been deployed since November 2022, as step down facilities to support acute and community hospital discharge and flow out of intermediate care. People who no longer met criteria to reside and were unable to directly return to their own home, were offered support at the appropriate level, helping them to stay as independent as possible. Feedback has been very positive, with people saying they felt more confident and independent, and that the workers helped them to do more for themselves. Alongside this, specialist in-reach exercise support was also commissioned, these specialists were able to support any activities as directed by a physiotherapist and suggest a suitable exercise programme for the individual. Where functional fitness testing was done, 100% of people who completed the Falls Efficacy Score Test improved, and 100% of people supported improved leg strength between Weeks 1 and 10 of the Pilot. This initiative was collaboratively delivered by system partners including: NCC; NWICB; Broadland Housing; Saffron Housing Trust; Norse Care; and County Kitchen Foods.
- Home Support Enhanced Discharge Incentive – capacity to support 10 additional discharges per week has been created by incentivising homecare providers with financial support to pick up new packages of care within 24 hours and covering increased complexity of discharge requirements (co-produced by Norfolk County Council and Home Support providers).
- Home Support Rate Increase – an increase of £1.08 to the hourly rate for homecare providers to enable an increased workforce and to encourage providers to take on additional work that supports flow into, and through, community care and supporting increased discharge activity (Norfolk County Council).
- Carers Hardship Support – information, advice and support for unpaid and family carers at point of discharge (acute and community) – focused on winter hardship support (co-produced by the Citizens Advice Bureau and Carers Matters Norfolk).
- Bed based intermediate care capacity – 158 intermediate care beds have been commissioned across Norfolk and Waveney with independent/private providers to

support individuals leaving hospital and with the associated 'wrap around' workforce support from primary care, therapy and social work.

Many of the BCF schemes/services represent core services – such as the Local Authority's reablement service (NFS), the community healthcare contracts (which are part funded via the BCF) and residential placements for individuals with learning disabilities.

The introduction of the aligned Demand & Capacity Plan in September 2022 and the embedding of the Demand & Capacity Plan into the BCF Plan for the 2023-25 return has proven to be an important mechanism to bring system partners together to discuss the joint system model for prevention, admission avoidance and supported discharge. The Norfolk system has also been fortunate to have received a ministerial visit which included discussions on the discharge model and two preparatory workshops with John Bolton prior to the visit. In readiness for the BCF Plan 2023-25 submission and the Demand & Capacity Plan, the Assistant Director for Social Care & Health Partnership Commissioning has been meeting with each of the three Localities in Norfolk to discuss

- how the demand and capacity model is working for each Locality with a focus on discharges from the local acute hospital
- any gaps identified through the model and
- how the gaps can be addressed.

Development of the Demand and Capacity Plan has directly impacted on commissioning and strategic decisions that will directly impact on capacity over the next 6-12 months, including commissioning external provider for capacity and capability gaps on pathway 1, and stretch or reablement capacity.

Work on the demand and capacity models will continue beyond the BCF Plan submission, to ensure that the challenges facing each Locality are clearly identified and a plan to address any gaps/issues identified can be implemented prior to Winter 2023/24. For example, the current modelling does not include discharges from the mental health hospitals – this is a known gap which will require system-wide discussions to capture the challenges that this presents and agree how best to address them.

This has been complementary to a wider piece of work that has also been underway, supported by NHS England and Newton Europe, to identify the levers in the system that can be activated to improve Norfolk's discharge model. The initial phase of a system-wide Discharge Transformation Programme (DTP) has been completed and three workstreams are being mobilised with the aim of better preparing the system for Winter 2023-24, more information on these can be found later in this document

1. Deconditioning (processes, length of stay, and back door decision making) – reducing the length of stay in our hospitals through increased grip and more effective progression during the process of discharge.
2. Pathway volumes (intermediate care) – streamlining the processes into short-term bedded recovery support after an acute hospital stay (Pathway 2) and

ensuring an effective referral method in home-based recovery support (Pathway 1) to maximise outflow and throughput.

3. Long-term outcomes – ensuring sufficient recovery (including reablement) capacity & capability and consistent patient-centred high performing MDTs.

EMT, a key partner in the BCF, has requested an in-year review (2023-24) of the BCF schemes funded via the NHS's minimum contribution to ensure that they

- continue to
  - deliver the national BCF metric targets for Norfolk
  - align with the BCF priorities as set out by the Norfolk HWB
  - deliver Value for Money as BCF spend
  - include support for system-wide and Place ambitions
  - support equity of outcomes for individuals living in each of the five Places across Norfolk and Waveney
  - drive multi-agency, multi-disciplinary integrated system partner working
- incorporate any relevant learning from the findings of the Community Services Review (which is currently underway)
- are proactively managed by the commissioning leads – including the identification and monitoring of the metrics of success or intended outcomes for each scheme.

This review will form part of the wider review of schemes as discussed at the HWB Board.

National Condition 2

Use this section to describe how your area will meet BCF Objective 1: Enabling people to stay well, safe and independent at home for longer**.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at Place or Neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

RESPONSE

How are you integrating care and/or commissioning in a collaborative way to support people to remain independent at home?

For 2022-23, the Core BCF for Norfolk funded a range of schemes which deliver some of the most important integration priorities for our ICS, such as services which deliver community healthcare provision, reablement support, integrated equipment services, support for vulnerable

adults, community-based support for housing and Place-based schemes, some of which are delivered by VCSE organisations.

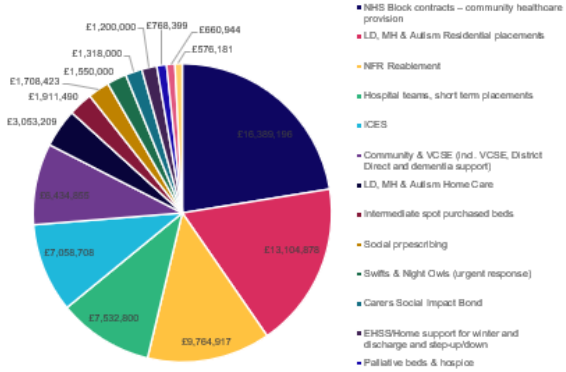
2022/23: Core BCF

Improving lives together
Norfolk and Waveney Integrated Care System

In 2022/23, the 'Core BCF' funded a range of service provision delivering some of the most important integration priorities in our ICS, including services that deliver community healthcare provision, reablement support, integrated equipment services and community-based support from District Direct and VCSE.

The BCF does not always deliver the entire cost of these schemes – for example, the majority of community healthcare block contracts within the Norfolk and Waveney system does not come from the BCF.

Priority	£ (22/23)	%
NHS community healthcare provision	£16,389,196	22.44
LD, MH & Autism Residential placements	£13,104,878	17.94
Reablement (Norfolk First Response)	£9,764,917	13.37
Hospital and follow-up teams, short term placements	£7,532,800	10.31
Integrated Equipment Service (ICES)	£7,058,708	9.66
Community & VCSE (incl. VCSE, District Direct and community dementia support)	£6,434,855	8.81
LD&A, MH Home Support	£3,053,209	4.18
Intermediate care beds	£1,911,490	2.68
Social prpescribing	£1,708,423	2.33
Swifts & Night Owls (urgent response)	£1,550,000	2.12
Carers Social Impact Bond	£1,318,000	1.80
Home support for winter and discharge	£1,200,000	1.64
Palliative care beds & hospice	£768,399	1.05
Integrated Care Coordinators	£660,944	0.90
Health & Wellbeing Partnerships	£576,181	0.78
Total:	£73,032,000	



We support people to make links with their communities to enable them to stay at home for longer and provide help with navigating the health and social care system. As part of the BCF, we fund both community connector roles and universal services to support people to remain independent. For example :

- Integrated Care Coordinators (ICCs) – our ICCs work differently across each Place according to the local need. In North Norfolk, the ICC's receive referrals, primarily from GPs, for individuals who could potentially benefit from additional support from their community. Across all areas, the ICC's work with the person to look at their strengths and needs then, if appropriate, they will refer or signpost them to relevant community resources.
- Carers' Support Services – 'Carers Matter Norfolk' offers information, advice, guidance and where appropriate assessment to support unpaid carers and help them navigate the health and social care system on behalf of their loved one.
- Norfolk Volunteer Services – encourages and enables people to use their time, skills, and talents to find meaningful and enjoyable volunteering roles, for their own benefit and for the benefit of their local community.
- Transport schemes – due to Norfolk's rural nature we fund transport services to support people to attend health, social care and wellbeing appointments.
- Social Prescribing – is a free and confidential service that works with individuals to support improvements to their health, mental health and wellbeing. Individuals can be referred to social prescribing by any professional in the health and care system. Social prescribers can make onwards referrals to a range of relevant services including VCSE organisations, primary care, secondary care and social care to support the person to achieve their goals.

How are primary, intermediate, community and social care services being delivered to help people to remain at home? This could include

- steps to personalise care and deliver asset-based approaches

- implementing joined-up approaches to population health management and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at Place or Neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Funding through Norfolk's annual BCF uplift was identified to support delivery of place priorities. £82,000 was allocated to each of the seven Health & Wellbeing Partnership area in Norfolk, a total of £574,000 utilising the Core BCF's annual uplift for planned spend by adult social care. A local process was developed to ensure project outcomes aligned with both our local and national BCF aims. Each Health & Wellbeing Partnership formed multi-partner Task & Finish Groups to lead the development of collaborative proposals, all of which were then agreed at the formal partnership meetings. For the current financial year and looking forward to 2024-25, it has been agreed that where existing projects meet the set criteria, funding will be continued. Based on last years' successes, it has been proposed to allocate further funding with the remit that projects will focus on Housing and Wellbeing.

A key aspect of many BCF schemes is the network of different providers and resources that work together to wrap services around the individual to address their needs, and where appropriate, the needs of the carer. For example

- Assistive Technology – the AT team can receive a referral from any professional working in the Norfolk health and care system, to either support the individual to remain at home or to return safely home post-discharge. Once received, the AT team assess the person's needs during a home visit and provide assistive technology equipment to support the person to remain safe at home – this can include detectors (smoke, heat, carbon monoxide), access (key safe, video doorbells) and personal alarms (falls detection, assistance alarms). AT can also be used to alert family, friends or call emergency services to a crisis developing in someone's home, allowing them to intervene quickly and where possible prevent a hospital admission. In addition, the Technology-Enabled Care providers of personal alarms can be linked to the urgent care responders for the Place, so if an automated or manual alarm is raised, they have the connections in the system to enable the person to receive an appropriate response – for example, a faller may raise their alarm and their TEC company can call the Swifts team to provide a 2h urgent care response for the person, rather than raising a 999 call. Upon visiting the person and supporting them to get up, the Swifts team may make onwards referrals to a GP for a medication check, a community healthcare Falls Prevention service, housing for adaptations, the Fire Service for a home safety check, etc.
- In My Place Carers Emergency Planning – unpaid carers are encouraged to register a contingency and emergency plan with the Local Authority. The carer is asked to detail a plan to be activated if they or their loved one experiences an emergency or crisis, particularly if they are unable to deliver care. Once registered, the carer receives a carer's emergency card which states that they are a carer and that someone is relying on them to keep them safe and well. The card has the emergency helpline number and the number of the registered plan. Once phoned, the emergency helpline service can help by contacting any contacts named in the

plan and can arrange temporary emergency care for the cared for person depending on the circumstances.

The ICS has been making real progress with the prevention agenda, both through population health management techniques and by commissioning preventative services. Schemes have taken into account the Equality Act and CORE20PLUS5 - examples include

- Active NoW: Health and care professionals working with patients who could benefit from being more physically active now have a consistent, simplified way to refer patients into physical activity through Active NoW. The programme supports inactive patients who do less than 30 minutes of exercise each week, as well as patients living with a long-term health condition that could be managed or improved by being more active.
- The Wellness of Wheels Bus: To make it easier for people to get services, support and information, particularly people who do not access services in more traditional ways, we have introduced the Wellness on Wheels Bus. It visits communities across Norfolk and Waveney offering services such as vaccinations and screening, along with health and financial advice.
- Health and Care Wellbeing Hubs: We have opened our first hub in Norwich, which in addition to giving COVID-19 vaccinations, is also offering access to wider health support, lifestyle and wellbeing advice, and welfare support services.
- Green Plan: The ICB helped to develop the system's Green Plan for 2022-25, which sets-out the commitment of local health and care services to reducing harmful carbon emissions, which will save lives and improve health now, and for future generations.

Over the past 12 months, the Norfolk system has been looking at our model to prevent and respond to people at risk of falling and some key advances have been made through collaborative working to support this.

- A particular example is a new approach led by Norfolk County Council, working with Newton Europe, to develop and implement an artificial intelligence tool through the Connecting Communities programme which can read the 'free text' entries in social care case notes and identify factors in the notes with indicate that the person is at high risk of falling. A pilot of the tool using historic records evidenced that the tool was extremely effective at identifying this risk. The project has since moved to a small test group of live cases. Individuals are contacted, only if a high risk is identified, to discuss a range of next steps including access to self-help, access to strength and balance classes, home visits to identify and resolve risk factors at home that can be resolved, and/or a formal referral to a Falls Prevention therapy service.

Norfolk established a 'Protect NoW' team during the Covid pandemic to identify and contact individuals likely to be at high risk of an adverse experience with Covid and help to support them to reduce their risk/likelihood of infection. It was a collaboration of more than 20 organisations and partners including Local Authorities and the VCSE sector. This methodology has been successfully expanded to encompass other areas such as vaccination update, pain management, diabetes prevention and cervical screening. The Population Health Management Team has continued to support a range of projects in Norfolk and Waveney including

- Access to IAPT services – aimed at increasing awareness of and access to the Norfolk & Waveney Wellbeing Service (IAPT) for people experiencing mild to

moderate ‘common’ mental health problems such as anxiety disorders and depression. Data from the mental health Trust is combined with the risk identification and stratification tool to identify a cohort. Individuals are written to, advising them about the Wellbeing Service and how to self-refer. Those who do not respond are contacted with a phone call from the Health Improvement and Support Team. Letters are sent in batches, to manage flow of referrals within IAPT capacity. Service users are likely to be individuals who have recently been prescribed anti-depressants and/or anti-anxiety medication by primary care and who have not yet accessed the Wellbeing service. This project has increased GP Practice referral rates by up to 35%, with relatively high proportion of referrals being for individuals living in deprived areas and older people.

- Digital Weight Management service: aim to increase awareness and uptake of the Digital Weight Management Programme (DWMP) in Norfolk and Waveney which supports local people to manage their weight and improve their health. The Health Improvement and Support Team target individuals living in the most deprived areas and where there is the lowest take up of the DWMP programme. Cohorts are identified through GP Practice data systems and are focused on adults living with obesity who also have a diagnosis of diabetes, hypertension or both. Letters and SMS messages are sent to the individuals to advise them about the Digital Weight Management Programme and how to register interest for a referral. Those who do not respond are contacted with a phone call from the Health Improvement and Support Team. The service can help reduce the risks linked to health conditions related to being very overweight including Type 2 diabetes, cardiovascular disease, joint problems, mental health problems and some cancers.

Whilst not all services are directly funded through the BCF, they are resources that heath and care staff can draw on to support people living in their own homes and communities.

There are many multi-disciplinary/multi-agency teams across Norfolk which work together to help people to remain safely at home. Examples funded by the Core BCF include;

- Great Yarmouth Early Help Hub - which supports individuals at an early stage with issues such as social care, homelessness, welfare, benefits and mental health. Regular meetings are held to consider whether system partners can add more value by intervening in a collective way to achieve better outcomes for the person. This approach reduces the risk of duplicate referrals, reduces delays and is helping to establish strong partnerships between the public, communities and voluntary services.
- Network of Escalation Avoidance Teams (NEAT) – the NEAT teams are Place-specific and are designed to coordinate a personalised community-based response for individuals experiencing a health and/or social care crisis, helping them to remain safely at home and providing appropriate support to resolve the crisis. Resources working under the NEAT umbrella include colleagues from social care, health care and mental health services. The teams can refer into 30+ services (such as housing, social prescribing, assistive technology) to customise the response depending on the person’s needs. NEAT receives referrals from a wide range of health and social care professionals, including GPs and the Ambulance Trust.

A particular example of working together to help people to remain at home in a crisis, is the Access to the Stack model which has been successfully adopted by the Norfolk & Waveney system.

In the Access to the Stack model, a clinician from the Ambulance Trust (EEAST) proactively identifies specific cases from their overall list of cases ('stack') as potentially suitable for a non-emergency response from a community health or social care colleague. Technology is used to enable the community team to access the case and determine whether there is an appropriately skilled community resource available to support the case.
If the case is accepted, then a transfer of care is completed, and the Place-based community team becomes accountable for responding to the individual in need i.e., the case is removed from the ambulance stack. For example, an individual who has had a non-injurious fall or has sustained minor injuries due to a fall may responded to by a community-based resource located in the Neighbourhood or at Place – this frees up the ambulance crews to respond to emergency cases.
The Core BCF funds all the community-based teams which participate in Access to the Stack, either via the block contracts with the community health providers or via specific schemes for teams providing an urgent care response such as Norfolk First Support, Swifts and Night Owls.

In 2022-23 the DFG spending was a challenge, due to increased costs for building works against static DFG budgets. This has impacted on our City, District and Borough Councils, who completed nearly 1,400 adaptations in 2022-23. Demand has been such that our Councils have had to look for different funding sources for additional housing services, such as handyperson schemes, where in the past they may have been DFG funded. The delegated BCF funding to Health and Wellbeing Partnerships has supported schemes working to provide home adaptations. A number of districts have specific RRO schemes to support individuals and their unpaid carers.

National Condition 2 (continued)

Set out the rationale for your estimates of demand and capacity for intermediate care <u>to support people in the community</u>

- learning from 2022-23 such as
    - where the number of referrals did and did not meet expectations
    - unmet demand i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services e.g., admissions avoidance and improved care in community settings, plus evidence of under-utilisation or over-prescription of existing intermediate care services
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimates there will be gaps between the capacity and expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans?

<u>Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community</u>

RESPONSE

Modelling demand and capacity is a key means of enabling us to understand the impact of making changes in our system on future activity, demand and the supply of services. Colleagues across our ICS have been working to develop a demand and capacity plan for hospital discharge, in order to deliver the following objectives:

Objectives:

- A single plan that projects hospital discharge demand, capacity to respond to that demand and the impact of actions on both
- Increasingly base decisions (including example commissioning, service design and strategic operational planning) on a greater evidence based provided by demand and capacity planning
- Develop in to a 'live approach' – where we build plan accuracy and detail over time, taking an agile approach that does not wait for the perfect model to be developed before we take action
- Monitor against plan and build in other contributing factors including admission avoidance and longer term outcomes
- Develop following principles of transparency, trust and collaboration – model is designed to support our collective and individual decision making and insight has been shared between partners explicitly in that spirit

The Demand and Capacity (D&C) Plan submitted to accompany the BCF Plan is a story of two halves. The ICB's Business Intelligence team were able to populate the Demand templates by accessing source data previously submitted as part of the Operating Plan for 2021-22 and applying a set of assumptions to the data, including an uplift to reflect expected population growth.

However, the collation of capacity data was more challenging and has required identifying each of services within the scope of the given definition of intermediate care, as referenced in the BCF guidance. We then had to liaise with providers, commissioning leads and BI teams to capture capacity forecasts against the previously unused metric i.e., 'the ability of the service to accept new referrals in the month'.

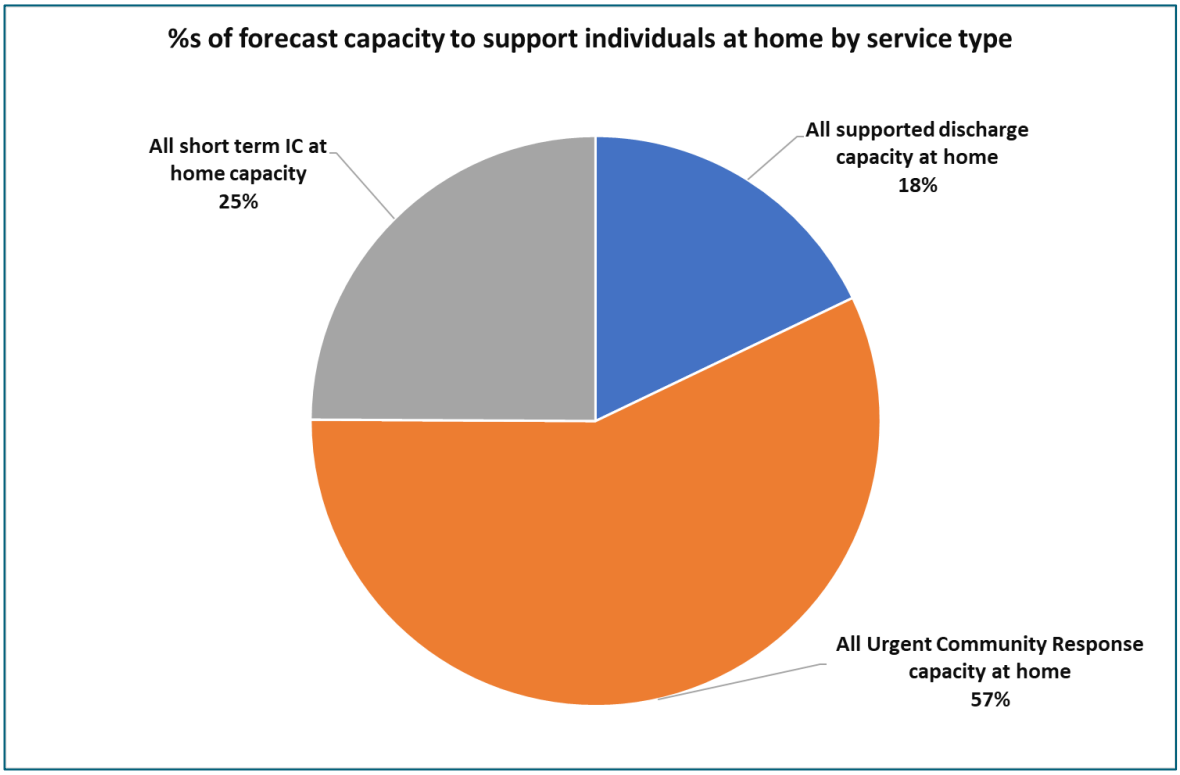
The East Locality within the NWICS footprint crosses the county border, so it includes East Norfolk and the Waveney area of Suffolk. This required calculations for demand and capacity to be allocated across the divide, so that data could be provided to populate the Norfolk BCF Plan and the Suffolk BCF Plan.

When this was first collated for the September 2022 return, the complexities of identifying and populating the capacity data against the short timeline for the collating the submission meant that there was limited time to reflect with senior stakeholders on the data presented in the D&C Plan and what it was telling us about the Norfolk and Waveney system.

The collation of data for the D&C Plan for 2023-24 has followed a similar initial process to the previous submission. However, following our learning from the initial submission, this time we have been working with system colleagues to review the datasets prior to the

formal submission which has been particularly useful – more information on this can be found against National Condition 3.

Capacity in the community



The 'at home' capacity forecast data indicates that 57% of the system's capacity to respond is focused on UCR to support individuals experiencing a health and/or social care crisis at home and prevent any unnecessary A&E attendances and/or hospital admissions. However, it's important to be aware of some of the subtleties behind this headline, which include the following.

- Many teams that provide UCR and follow-on short term intermediate care responses at home, also provide supported discharge care at home – so the split of the capacity across all three service types has been done using best estimates
- One to many relationships: a single referral may result in a response from multiple teams and the capacity has to be 'ready to respond' in each of those teams, i.e. this is not a double-counting issue – for example a supported discharge may require a VCSE settling in service, support from a reablement team for functional improvements, support from a clinically-led rehabilitation team for recovery of health related issues and support from a mental health team to support improvements to mental wellbeing. Similarly, a crisis at home for an individual with complex needs will also require a multi-agency, multi-disciplinary response.
- An 'at home' response may also involve teams which are not aligned to the service types in the BCF guidance but are part of the Core BCF schemes e.g., Assistive Technology, the Integrated Community Equipment Service and District Direct housing services.
- A new aspect of the D&C Plan this year has been the requirement to ensure that services providing support for individuals with learning disabilities, autism and/or

mental health needs are fully represented. Many services in Norfolk & Waveney can support individuals with learning disabilities, autism and/or mental health needs as part of their overall cohort of service users.

However, there are also specialist services providing support for individuals with more complex needs, many of which operate with small caseloads. Commissioning colleagues from the ICB and the Local Authority have confirmed that individuals with complex learning disabilities, autism and/or mental health needs in 'intermediate care' specialist services - as a step-down from hospital or a step-up from the community/home – are often with the service for a minimum of six months before being able to return home or move to a longer term solution that is suitable for the person's needs (which may be custom-built) and enables them to live as independently as possible.

We have taken the decision to include forecasts for these specialist intermediate care services for individuals with complex learning disabilities, autism and/or mental health needs in the data, as they are relevant and are part of the overall demand and capacity model for Norfolk.

- VCSE system partners provide a Complex Community Support team, which is support worker led making contact either face to face or via phone with the person in need, typically for 6-10 weeks per case. The funding is roughly 50/50 Norfolk County Council and ICB with a small amount from Suffolk County Council.

National Condition 2 (continued)

Describe how BCF funded activity will support delivery of BCF Objective 1: Enabling people to stay well, safe and independent at home for longer**,** with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

RESPONSE

During 2022-23, there was a system-wide focus on falls prevention and response – this included

- NWICB completed a mapping of all falls-related schemes across the system delivering either falls prevention, an urgent response to fallers and all projects/initiatives that were underway to improve aspects of the falls pathways.
- An ICS Falls Group was set up in September 2022, chaired by the Associate Director Quality & Safety (Patient Safety Specialist) from the Norfolk & Norwich University Hospitals NHS Foundation Trust and attended by representatives from the various system partners in the ICS.

- A Task & Finish Group was set up to deliver the requirements of the Going Further for Winter: Community-based Falls Response national initiative. A significant number of schemes were explored under this work. An important outcome from this work was the provision of supplementary falls equipment to all BCF-funded UCR teams across the Norfolk and Waveney footprint. For example, the West UCR team requested additional batteries for the existing Manger equipment – this would enable them to be more efficient and responsive by being able to swap out a battery that had been depleted, with one that was fully charged, when out and about rather than having to come back to base and wait for the battery to re-charge.
- Refresher training for Care Home staff in every care home in Norfolk on falls prevention and management, including the use of the I-Stumble app and the provision of Manger Elks to enable staff to help people back up after a non-injurious or minor injury fall.
- Under the 'Connecting Communities' programme, Norfolk County Council has developed an Artificial Intelligence tool to identify individuals at high risk of falls and work with system partners to reach out to those identified through the project (see previous answer to National Condition 2).
- The development of a Norfolk & Waveney Long Lie Pathway, based on the NICE guidance, with input from ICS partners.
- The agreement that Active Norfolk should develop and deliver a falls prevention approach using exercise specialists to enable individuals to improve their strength and balance to reduce the likelihood of a fall. Active Norfolk also supported deconditioning work at the local acute hospitals.

In 2023-24, the initial falls activity is being consolidated under a single NWCIS Falls Programme, led by the ICB's Director of Quality in Care, with three workstreams

- Acute and Inpatient settings
- Community, including VCSE
- Care Homes.

The overall aim is to provide cohesive falls prevention and response pathways, using all relevant system partner resources to 'tip the balance' for the Norfolk and Waveney system from falls response to falls prevention, to better support the population and enable more people to stay safe, well and have the confidence to remain independent in their own homes. Whilst not all initiatives are funded directly funded through the BCF (with the exception of the UCR team), the programme of work supports BCF objectives.

National Condition 3

Use this section to describe how your area will meet <u>BCF Objective 2: Provide the right care in the right place at the right time.</u>

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and

social care services are being delivered to support safe and timely discharge, including

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- how additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

How are you integrating care to support people to receive the right care in the right place at the right time? How is collaborative commissioning supporting this?

RESPONSE

In Central and West Norfolk there is an integrated Operational Director structure between the Local Authority and the Community Healthcare Provider for the management of the key multi-agency, multi-disciplinary frontline services in the community – this includes

- the HomeFirst/ToC Hubs (for triage and management of supported discharges)
- the NEAT teams (for triage and management of complex admission avoidance cases where the individual is experiencing a health or social care crisis)
- Urgent Community Response, and
- short term intermediate care (reablement and rehabilitation) for supported discharge and admission avoidance cases.

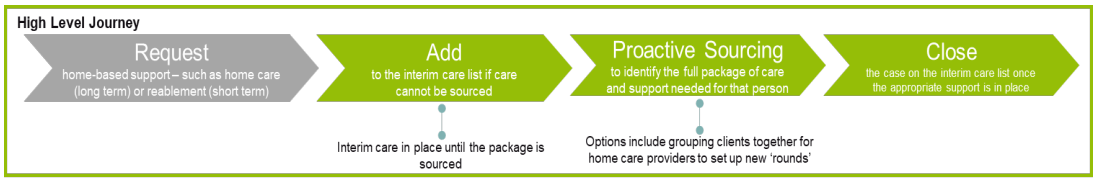
In East Norfolk and the Waveney area of Suffolk, the Community Healthcare Provider uses multi-disciplinary Primary Care Home teams which operate at Neighbourhood level to support discharges, UCR and admissions avoidance cases. The Primary Care Home teams work closely with the Local Authority UCR teams to ensure the right care is delivered by the right resources at the right time.

All of the frontline teams can refer onto other relevant services to support the individual's needs – such as Assistive Technology, falls prevention services, social prescribing, GPs, mental health services etc.

Whilst the aim is to deliver consistent outcomes for the local population across the NWICS, each Place delivers the outcomes through a local model of care designed to meet the needs of their area. For example, Norwich Place has HomeWard which is a multi-disciplinary team supporting discharges and complex admission avoidance cases and the Norwich Unplanned care team which supports admission avoidance cases. There is also a nurse-led Home Visiting Service in primary care which provides support to GP Practices and can collaboratively support cases in association with HomeWard. Where individuals are identified as having highly complex needs, they can be referred to the Community Fully Integrated Care & Support pathway (Community FICS) which brings together medical, health, social care, housing and voluntary organisations to discuss the case and develop a clear action plan to meet the person's needs. This ensures that person's needs and the care plan is developed using a cross-sector, multi-agency approach. Integrated Care

Coordinators (ICCs) - funded by the Core BCF - track and monitor the person's journey whilst on the Community FICS pathway. The MDT will continue to discuss the persons needs until the intended outcomes from the referral have been met, or the person or the members of the team feel Community FICS is no longer needed.

Following targeted work, the number of Norfolk residents for whom packages of home care cannot be fully sourced has reduced since January 2022 by 90%, from 887 people to 86 people – bringing the Interim Care List (ICL) to one of its lowest levels in 3 years. 10 of those people are in acute hospitals, the rest are predominantly in the community in their own homes.



A gap remains in the funding for the current bed-stock following the ceasing of 'Winter Funds'. These funds have been focussed on support discharge through increasing capacity and the associated infrastructure/wrap round care to enhance delivery/effectiveness. They have enabled us to deliver the following capacity

<u>How are primary, intermediate, community and social care services being delivered to support safe and timely discharge, including</u>

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance?

RESPONSE

NWICS Discharge Transformation Programme

The Norfolk and Waveney system has experienced many of the challenges that have also been felt nationally - including demands on health and social care, multiple short-term funding and initiative cycles and wide-ranging workforce challenges. There are also several local system challenges

- digital immaturity
- geographical spread – few urban conurbations and significant areas of rurality
- one of the fastest growing populations of older people in England
- an underlying deficit as an ICS which we have been mitigating for several years.

System partners in N&W have recently made good progress in reducing pressures on discharge, including strengthening community based capacity (intermediate care and long term care and support) and looking at processes, including in our discharge hubs. This has resulted in improvements across our UEC system, including

- acute bed occupancy by patients with NCTR coming in line with England averages
- improvement to capacity in care and support, including
  - recovery capacity in reablement services
  - increased capacity in homecare following recovery.

To continue this momentum, NWICS is embarking on the Discharge Transformation Programme (DTP) to improve discharge outcomes and experiences for our population and our staff. The DTP is intended to realise financial benefits and build transformational capability within the system. It is interconnected with several other NWICS transformation initiatives, including Adult Social Care's front door and short term services offer ('Connecting Communities' programme), long-term sustainable changes for children and young people ('Flourish' programme) and a review of community health services.

The key objectives of the DTP are to enable more people to

- go directly home after their stay in hospital (Pathways 0-2)
- go home rather than to a residential placement, following recovery
- live at home more independently (long term outcomes).

The workstreams under the DTP will focus on

1. Deconditioning (processes, length of stay, and back door decision making) – reducing the length of stay in our hospitals through increased grip and more effective progression during the process of discharge. Improving the effectiveness of our MDTs to ensure people can go out on the most appropriate pathway. *This is the biggest driver of non-ideal outcomes across the system, and practitioners have identified 14 days where we could have done better for some our patients with the longest stays in hospital.*

2. Pathway volumes (intermediate care) – streamlining the processes into short-term bedded recovery support after an acute hospital stay (Pathway 2) and ensuring an effective referral method in home-based recovery support (Pathway 1) to maximise outflow and throughput.

   Aiming to offer more effective short term recovery services in people's homes, such as reablement, to everyone we support. No one should enter long term homecare without reablement if they could have benefited from it.

3. Long-term outcomes – ensuring sufficient recovery (including reablement) capacity & capability and consistent patient-centred high performing MDTs. Aiming to increase home-based recovery capacity by 10% to enable more people to be sent home with the appropriate support and ensure that trained reablement resources are no longer used to deliver long term home care packages. *Practitioners have identified people who end up in long term bedded care that did not achieve their ideal long-term outcome and could have gone home with support. Some people ended up in long-term home care that did not achieve their ideal long term outcome and could have gone home with a more independent package. This is impacted by deconditioning (processes, length of stay and back door decision making) that increases pressure on recovery capacity and capability.*

The combination of process and pathway changes is intended to reduce the need for longer term care arrangements. Reducing deconditioning and improving timely decision making should ultimately result in less people requiring long term placements in residential / nursing homes and should enable more citizens to live independently in their own homes for longer with smaller packages of home care, where required.

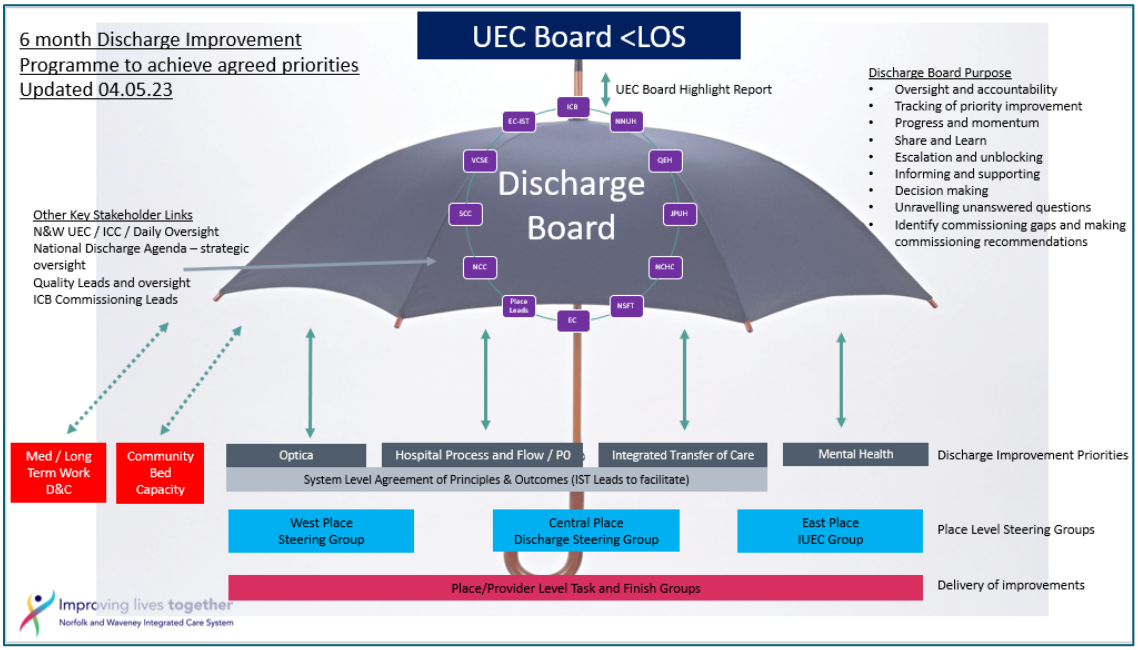
To underpin the DTP successfully there are some key operational deliverables

- A new patient flow tracking system to work across the length and breadth of our pathways.

- Redesign of Pathway 1 recovery services to ensure consistency and flexibility across as much of the system as possible – building on the recently increased availability of recovery support, such as reablement
- Redesign of our hub model and MDTs to ensure the right balance of ownership and input from our specialists.
- Redesign of the ToC process to reduce burden.
- Investigation into the reintegration of hubs into the Acutes to streamline processes.
- Redesign of our discharge performance management model, including the roles, data and visibility required to drive and sustain the change including transformation investment to overcome these hurdles to collate and join data from across the system.

To deliver a successful transformation, we will also need to tailor the solutions to account for the impact of Place as West, Central and East Norfolk have differing problems and root causes.

To help drive the DTP, the system has established a governance model which includes a Discharge Board to ensure that interactions between the various transformation activities in the system are fully understood, timelines de-conflicted and, where appropriate, activities are combined to reduce duplication of effort and streamline outcomes.



(PR5 - An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.)

How is the additional discharge funding being used to deliver investment in social care and community capacity to support discharge and free up beds?

The BCF Additional Discharge Fund has been positively received by allowing the system to place a particular emphasis on supporting people to return home. The Discharge Fund has also played an important role in delivering changes that have enabled wider system improvements to discharge.

Our system decided to focus on three key areas, with a particular emphasis on supporting people back to their own home:

Workforce: We have increased the hourly Home Support rate to support providers to recruit and retains staff. This has had a positive impact, increasing the number of packages of care taken on and reducing the Interim Care List (people waiting for a long term home solution).

Mental Health, LD&A: funding supports 6 units of accommodation for people being discharged.

Direct Care Capacity:

a) Step-down Housing with Care flats – short term care for individuals unable to go straight home from hospital, includes a reablement offer

Carers Hardship support – dedicated support for Carers to access hardship support provided by Citizens Advice Bureau and Carers Matters Norfolk

Community and Discharge Support service – funding has afforded the opportunity to develop a new model offering short and medium term support for low level and more complex needs. Support on discharge and admission avoidance.

Sustained support to the Discharge Hubs – giving job security and stability to the teams to allow development of processes and improvements.

The full funding allocation for 24/25 has yet to be agreed and we welcome the flexibility to be able to review this during the year. This will enable current schemes to bed down and be monitored so informed decisions can be made on the most appropriate schemes that best meet the needs of the system and of the residents of Norfolk.

(PR5 - An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.)

How are you implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow?

NWICS has benefited from sustained support from NHS England and Newton Europe who have collated evidence and are supporting the strategic leaders in the Local Authority, ICB, acute and community providers to determine the priority areas to improve discharge processes across the system. Their expertise has been essential in the development of the single, system-wide Discharge Transformation Programme.

In May 2023, NWICS also benefited from inputs from

- John Bolton, who led two meetings to discuss the opportunities and challenges associated with the discharge process in Norfolk and Waveney, providing the benefit of his knowledge and expertise to the help shape the next steps

- a Ministerial visit with Executive Leaders from the system to discuss the opportunities and challenges associated with the discharge process, which included feedback on an early draft of the BCF Demand and Capacity Plan for 2023-24.

Data shared on the ministerial visit and with John Bolton included:

- Home based recovery: 63% of people are re-abled on discharge with 37% partially re-abled
- Long term care following recovery: following targeted work, the number of people waiting packages of care of care on the interim care list has fallen to one of its lowest levels in 4 years. The list of people awaiting care is a leading indicator of home care capacity.

We want to be able to offer more effective short term recovery services in people's homes, like reablement, to everyone we support with no on entering long term homecare without an offer of reablement if they could benefit from it. The ADF is enabling us to grow our services, both our reablement offer and home care offer.

The Discharge Transformation Programme (see earlier section) and governance arrangements are intended to address the current issues, whilst also setting the system for continuous improvement to transform the Intermediate Care model beyond the initial deliverables to achieve our aims of shorter hospital stays, twice as many people going directly home after hospital, 1 in 3 people at home with a package of care living more independently and more people with mental health going home rather than to a residential placement.

National Condition 3 (continued)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include

- learning from 2022-23 such as
  - where number of referrals did and did not meet expectations
  - unmet demand i.e., where a person was offered to support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact of work to reduce demand on bedded services e.g., improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services.
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF Plan as a result of this work
  - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
  - how have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

(PR5 - An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.)

RESPONSE

The collation of data for the D&C Plan for 2023-24 has followed a similar process to the previous submission. However, using our learning from the previous submission, this time we have been working with system colleagues to understand the implications of the Demand & Capacity Plan.

Following advice given by John Bolton, the Norfolk Assistant Director for Social Care & Health Partnership Commissioning has been working with each of the three Localities in Norfolk to discuss the details of their local intermediate care demand and capacity model.

This dialogue has proven to be particularly useful and has since resulted in

- a fully interactive model in Excel which can enable different scenarios to be viewed in terms of their impact on services and capacity
- an increased awareness of challenges that the datasets when trying to collate a single view of capacity – for example, Norfolk County Council's discharge dashboard contains data for NCC commissioned and provided services (NFR, PoC etc), which only accounts for 60-70% of discharge demand for Pathway 1
- identifying Locality gaps and issues arising in the capacity available to meet the discharge demand generated by the local acute hospitals and in response to demand from the community to help people remain at independent or supported in their own homes
- capturing a system baseline - so that future variations in demand and/or capacity and initiatives intended to 'improve' operational flow can now be compared to the baseline to evidence their impact and contribute to informed decision-making.

To address known challenges with capacity to support discharges into reablement services, the Local Authority has used BCF funds (Core and ADF) to commission additional short term domiciliary services and incentivise home care providers to help bridge the gap and enable more timely supported discharges to home. This has included an increase in fees which has come at a time of significant financial pressure for NCC and Adult Social Services, however the Council was responding to increased costs facing care providers, including the National Living Wage and inflation.

Value from the exercise:

- Forming a picture of demand and capacity that could provide invaluable insight that drives future decision making
- Insight is already informing commissioning and strategic decisions that will directly impact on capacity over the next 6-12 months
- Highlights the importance of admission avoidance in reducing demand, alongside capacity

Key findings:

- Focus plans related to processes for PO, use of voluntary sector and admission avoidance/SDEC and Virtual Ward
- Home-based recovery (pathway 1) - Partners developing plans to stretch existing provision and commission additional services. No. of discharges has exceeded projections so far this year, however capacity is in place to meet demand

- P2 – number of expected discharges exceeds current available and planned capacity
- P3 work plan to enhance pathways is required around optimum and effective provision
- Models of care conversation are required at place level to take forward the data and solutions including application of efficiency and effectiveness measures.

Work on the demand and capacity models will continue beyond the BCF Plan submission, to ensure that the challenges facing each Locality are addressed prior to Winter 2023/24. For example, the current modelling does not include discharges from the mental health hospitals - this is a known gap which will require system-wide discussions to capture the challenges that this presents and agree how best to address them.

National Condition 3 (continued)

Set out how BCF funded activity will support delivery of BCF Objective 2: Provide the right care in the right place at the right time, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics

- Discharge to Usual Place of Residence

(**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)**

RESPONSE

The key change for the BCF is the opportunity to plan for delivery over two years as opposed to one year as has been to case up until now. This means that we have an opportunity to look further forward with our planning cycle, allowing NCC, the ICB and our partners to better meet our aims.

The vision for the BCF in 2023 – 2025 is supported by two core objectives;

- Enabling people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time.

We are increasingly working towards aligning the BCF with the new ICS places, supporting local joint health, care and housing work. This includes collaborative proposals from Health and Wellbeing Partnerships with funding through the annual BCF uplift to support localised delivery of the BCF.

New for 23/24 is the recently formed Joint Social Care and Health Assurance Board, this board will oversee integrated working across adult social care, children's services, the ICB and Suffolk County Council for Waveney. DFG colleagues from the districts were invited to the June meeting where the home adaptation needs of children and young people, especially those transitioning to adulthood were discussed and will form part of the review of BCF services undertaken this year.

The Core BCF is used to fund all short term intermediate care services delivering reablement and rehabilitation across the Norfolk and Waveney footprint which are either provided by the Local Authority or the community healthcare organisations.

Norfolk First Support (NFS), the reablement provider in Norfolk, have been driving initiatives to improve service capacity, effectiveness and their ability to respond to demand to maximise the impact it has as a service. As a result, NFS capacity has substantially increased, and it is estimated to be able to support 1500+ more individuals over the next year. Further discussions with NFS have enabled NFS to provide 'stretch' capacity to better support the discharge demand however this has to be complemented by additional short term home care provision.

To address challenges with capacity to support discharges into reablement services, the Local Authority has used BCF funds (Core and ADF) to commission additional short term domiciliary services and incentivise home care providers to help bridge the gap and enable more timely supported discharges to home. It has also commissioned 6 new units to enable supported discharge to an interim home-type environment for individuals experiencing complex mental health issues.

Both the Local Authority and the ICB have used ADF to stabilise the funding for the HomeFirst/ToC Hubs, which triage and manage all supported discharges, which were previously funded via various short-term funding routes. This has been an essential step to reduce the turnover rate of staff working in the Hubs by providing security of employment.

The Core BCF is used to fund the District Direct scheme which enables dedicated District Council resources to identify and overcome housing related barriers to discharge, working as part of the multi-agency, multi-disciplinary HomeFirst Hubs. The aim of the service is to enable residents to return home in a timely manner from hospital to an environment that meets their needs, with all necessary support in place. Whenever possible, potential issues with returning home post-discharge are flagged to the District Direct team soon after a hospital admission. The aim is to resolve these issues prior to the person being confirmed as ready for discharge, with the intention of preventing any last-minute delays to discharge due to housing related issues.

The Integrated Community Equipment Scheme (9.66% of Core BCF budget, jointly funded by the ICB and NCC) and the Assistive Technology team are key to enabling people to return home by ensuring that they have the right equipment at the right time to keep them safe and enable independence when they return home whenever possible. The AT team changed their model in 2022 to include an assessment of need at point of discharge and provision of suitable equipment (e.g., pendant alarm, smoke alarms, carbon monoxide detectors, motion sensors etc.), followed by a full assessment of need once the person is home and settled into the environment.

National Condition 3 (continued)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

RESPONSE

Our strategic work on developing the HICM commenced in the latter stages of 2021. A small number of workshops were held with the support of the LGA. This work coincided with the development of the ICS and place based structures changed. With new partnerships being formed, there was a desire expressed at the end of 21/22 to place this work on hold. Now that we have more established Place Boards, we feel this is now the time to develop our strategic approach with partners and have spoken with Isla Rowland, keen to take up the offer of support.

As a system we continue to work together to improve the management of transfers of care informed by the work of Newton Europe on discharge processes at the three acute hospitals and our Demand and Capacity Planning. A number of our schemes focus on multi-disciplinary working to support discharge and we are re-designing our offer from the VCSE for short and medium term support.

National Condition 3 (continued)

Please describe how you have used BCF funding, including the i-BCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered.

RESPONSE

The BCF funds additional social work capacity to support Care Act Implementation related duties including Deprivation of Living Safeguards, across older people, working age adults and mental health. This additional resource has enabled social work teams to reduce waiting lists and ensure more timely responses to vulnerable people.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carer's breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Carers play a vital role in the health and wellbeing of Norfolk. They are key to maintaining the independence of people with care needs. However, providing care can have a major impact on carers' lives and we all have a duty to support them. There are around 81,000 people in Norfolk providing essential support to a family member or friend, according to 2021 Census dat0061. They may not think of their role as a 'carer' or know that support is available to them.

In Norfolk, the BCF funds the Social Impact Bond for Carers. This service, which was launched in September 2020, delivers an enhanced offer for carers in Norfolk. Under the brand name "Carers Matter Norfolk" it provides our carers with a single place to go for any support they need in their caring role.

Norfolk has delegated its Carers Assessment function to Carers Matter Norfolk, meaning it can offer support from one-off queries from carers to its advice line all the way up to a full Carers Assessment with ongoing support from a Family Carer Practitioner. The range of support offered by the service allows it to be flexible to meet carers needs, wherever they are in their carers journey. As part of this support, they can also offer carers access to a Health and Wellbeing Fund and Carers Breaks.

In the first two and half years of the service, there have been 4.417 new carers who were not previously known to Carers Matter Norfolk, registered with the service. 2,715

carers have had a Carers Assessment, and 1.050 have received high-level support. This represents a success story for the BCF in funding carers support and gives a platform to build on to develop further support for carers in our county.

The service has also supported the following.

- 663 people to sustain their caring role for 6-months post assessment
  This represents 85% of all 6-month checks
- 357 people to sustain their caring role for 12-months post assessment
  This represents 84% of all 12-month checks
- 506 people to increase their wellbeing after 6-months post assessment
- 89% of people who complete a carers star two increased their score by at least two points from carers star 1.
- 273 people to increase their wellbeing 12-months post assessment
- 93% of people who completed a carers star three increased their score by at least 2 points from carers star 1.

We also deliver support to our carers outside of the BCF funded services through

- a Carers Passport scheme with all three acute hospitals in Norfolk – allowing carers a way to identify themselves as carers when their cared for person is in hospital, and to discuss extended visiting hours to support their cared for person.
- In My Place Emergency Planning – support carers to develop an emergency plan held by NCC which can be enacted in the case they have an emergency to make sure their cared for person still received the necessary care.
- Carers Charter – a charter coproduced between NCC and carers to outline both our ambitions and commitments to all age carers across Norfolk.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

(**PR3 - A strategic, joined up plan for Disabled Facilities Grant (DFG) spending)**

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

- To enable people to stay well, safe and independent at home for longer
- To provide people with the right care, at the right place, at the right time

Housing adaptations, including those delivered through the Disabled Facilities Grant (DFG), support the BCF objectives by helping towards the costs of making changes to people's homes to enable them to stay well, safe and independent at home for longer.

The right home environment is essential to health and wellbeing throughout our life. DFG adaptions for people with disabilities provide a lifeline to thousands of people every year.

They allow people to continue living in their homes independently. The Care Act requires local authorities to promote the well-being of individuals through supporting them to live in suitable accommodation, to prevent, reduce or delay the need for care and support and to work with statutory partners, including local authority housing departments.

In 2022/23 Norfolk Housing Authorities, in partnership with Adult Social Care, completed nearly 1400 individual adaptations, with nearly half of those costing under £5000 each. Each of these adaptations has contributed to people being able to live, independently, in their own homes. In addition to core DFGs all Norfolk Housing Authorities have, or plan to have, a Housing Assistance Policy which facilitates a range of additional support, from affordable warmth grants to hospital discharge grants.

Norfolk Housing Authorities and the County Council have agreed a shared mission statement and work in partnership on the seven agreed objectives. The strategic partnership facilitates a platform for all districts and Social Care to work collaboratively; the appointment of the Norfolk Housing and Independent Living Programme Manager supports this work.

Strong partnership in 22/23 has resulted in a management framework that evidences the activity and benefits of Norfolk's integrated approach to DFGs and will support continuous improvement and innovation. Engagement and reporting through the local Health and Wellbeing Partnerships will ensure system wide understanding and support of how DFGs contribute to the objectives of promoting independence.

Plans formulated by the seven Norfolk Local Housing Authorities detail how they will continue to deliver essential DFGs and a range of other services that make a significant impact on people's lives; allowing them to live independently and safely within their own homes.

Each District, Borough and City Council has a Health and Wellbeing partnership (HWP) with a Vision and purpose statement as part of the Integrated Care System (ICS) and Integrated Care Board (ICB). Linking the objectives, outcomes and the work specifically for the DFGs and more widely for the IHATS will demonstrate the join up of the work around maintaining residents' health and wellbeing, helping them stay independently for longer. There are plans for plans to be presented at each of the HWPs in the coming months.

In Kings Lynn and West Norfolk, the Health & Wellbeing Partnership Priorities link to the DFG service delivery:-

- Prevention – led approach to delivering equitable support and services based on evidence-based need and sustainability.
- Engagement & Collaboration – by working in partnership with our communities and organisations.
- Address Health & Wellbeing Inequalities – through building primary prevention, self-care and resilient communities.

Key points from plans point to the growing demand for home adaptations and the increasing costs of building and construction work. Workforce challenges – the availability of occupational therapists and within the construction industry cause delays.

Boroughs are committed to the use of DFGs and RRO policies to offer flexible solutions to ensure disabled residents can access and benefit from adaptations to their property to enable them to continue to live at home.
Districts are keen to review and streamline DFG processes to reduce time between referral, triage(for example South Norfolk and Broadland), and the works being carried out and are particularly keen to understand how the service has impacted on people's lives with follow up visits and calls post completion to survey residents(for example Great Yarmouth) to understand how the Adaptation has impacted on their health and wellbeing and report on these outcomes to the Health and Wellbeing Partnership.
The plans are embedded here for further reading.


Breckland DFG Locality Plan 2023-24


South Norfolk DFG Locality Plan 2023-24


GYBC DFG Locality Plan 2023-24 Final.pd


Broadland DC DFG Locality Plan 23-24.pc


Kings Lynn West Norfolk DFG Locality I


Norwich Disabilities Facilities Grants Local


North Norfolk DFG Locality Plan 2023-24

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) England and Wales Order 2002 (RRO) to use a portion of the DFG funding for discretionary services?

☒ Yes ☐ No

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

RESPONSE

All seven of our Districts use RRO's to use a portion of DFG funding for discretionary services. It is difficult to quantify the amount allocated to these discretionary uses in advance, as many of the RRO's fund services that are used on an as needed basis, rather than funding capacity.
Examples:

South Norfolk and Broadland have a number of grants under the RRO including;

- Forget Me Not Grant – for people living with Dementia and those caring for them to prevent admission or aid discharge
- Carer Support Facility Grant – adaptations or equipment to enable and assist family members who provider care and support for residents with disabilities.

Kings Lynn and West Norfolk -

- Adapt Grant for assist with hospital discharge cases
- Low level Prevention and Safe and Secure Grants helping residents stay safe and independent in their own homes

North Norfolk – the introduction of an RRO policy is due to be presented to cabinet in July 2023, if approved, internal procedures will be developed to ensure the policy is operational by the end of the summer 2023.
Breckland

- Relocation grant. To cover moving costs if the client identifies moving to a more suitable property as an alternative to a DFG.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with Protected Characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF Plan have been considered
- How these inequalities are being addressed through the BCF Plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as Local Authority priorities under the Equality Act and NHS actions in line with CORE20PLUS5.

RESPONSE

Those living in our most deprived communities experience more difficulties and poorer health outcomes. Health and Wellbeing Board members told us that this was magnified during the pandemic and gaps between communities widened. We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected. To be effective in delivering good population outcomes we need to most help those in most need and intervene by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale. Reducing inequalities in health and wellbeing will involve addressing wider issues that affect health, including housing, employment, and crime, with community-based approaches. These need to be driven by partnerships at a place level involving councils, health services, the voluntary sector, police, public sector employers and businesses.

District, City and Borough Councils work closely with partners to identify areas of increasing concern, poverty and inequality across Norfolk and Waveney. Health and Wellbeing Board Members told us that, through the pandemic, local resilience arrangements were key to providing clear messages and communication with communities, partners, and members. Communities have the knowledge, assets, skills, and ability to help their residents flourish. Communities and individuals that are able to meet their own needs have better outcomes. It is important that our services support those living in our communities to look after themselves and live an independent life for as long as possible.

As part of this the Place Boards - which bring together partners across each of the five Places in Norfolk - have been focusing on identifying the specific health inequalities experienced in their

area and how the demography, geography and community support available impacts on this. This work is still in its early stages of development, but it has been seen as an important factor in the decision to involve the Norfolk Places in the development of the system's BCF priorities.

As a system we are working to reduce health inequalities by:

• Using population health management techniques.

• Improving access to services, for example via the Wellness on Wheels Bus and the introduction of our Health and Care Wellbeing Hubs.

• Collaborating through our place boards and local health and wellbeing partnerships to improve access to and the quality of healthcare, as well as to address the wider determinants of health.

• Establishing a Patients and Communities Committee, whose remit includes examining how the ICB is reducing health inequalities.

Our collective work as a system is helping us to deliver the measures in the NHS Long Term Plan, the five priority actions to address inequalities that were identified as part of the health service's response to the pandemic and our work to deliver Core20PLUS5.

Our services are also developed with Equality Impact Assessments, which aim to understand and mitigate the potential inequalities experienced by people with protected characteristics as a result of new services or service changes. Many of our services seek to positively target inequalities, for example, by offering additional support to people with protected characteristics.

We are using population health management techniques to provide more anticipatory care and early intervention. We are also using technology to empower people to manage their health and wellbeing better, for example by giving people greater visibility and control over their treatment and care journeys – this is a key aim of our new Digital Transformation Strategy.

We are re-designing our Home from Hospital service, bringing it together with other VCSE services to form a new Community and Discharge Support Service. This service will provide a single point of access to an equitable countywide service that has increased support capacity, a framework approach to contracting with other VCSE services and onward referral to VCSE services that can meet the needs of individuals, building their local networks to increase their resilience. The service will have an outcome focused approach to encourage collaborative working between providers enabling a local community approach. It will also afford increased volunteering opportunities for local populations.

Currently, we have specific information and advice services within our BCF, targeted at those with protected characteristics and those groups/individuals know experience health inequalities, such as people with disabilities, older people, and unpaid carers. As the Place-based work on health inequalities develops and the system's understanding matures over time, Norfolk can start to use this knowledge to influence a more comprehensive targeting of BCF services to tackle inequalities.

As part of the BCF review we will be developing a comprehensive dashboard on the impact of our BCF programme, as detailed in the 'Executive Summary'. This alongside the 2021 census data, once it is published, will enable us to better identify and evidence inequality of outcomes related to how we deliver the BCF national metrics locally and their expected impacts on the people of Norfolk.

BCF Planning Template 2023-25

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 h

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

2. Question completion tracks the number of questions that have been completed; when all the questions in each sect of the template have been completed the cell will turn green. Only when all cells are green should the template be ser the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with tl word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are complete 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'.

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

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change t

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

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Car Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the B iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2(25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of y BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have n been published so are not pre populated in the template. You will need to manually enter these allocations. Further ac

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF poo These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Area should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £3(in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you plan 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 2022-23 (**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 to identify that these are underspends that have been rolled forward. All allocations are rounded to th 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 (plea also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF pl nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by ass to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services tl are providing. There may be scenarios when several lines need to be completed in order to fully describe a single sche or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consis 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. Pl 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 th 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 fie assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally a 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 tur "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field descrip for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possi as this data is important in assurance and to our understanding of how BCF funding is being used nationally.

5. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will 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 accep numeric characters.

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

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.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field descrip for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

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 fundir 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 inclu 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

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 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 (£) 2023-24 & 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 forwa

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that sch type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of B 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 c you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expectec spend in that category in the BCF over both years of the programme divided by both years total spend in that same

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems shou review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplannec 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 incl 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 qu
in 2023-24. 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
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 reference year. The expected value is t
observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- 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.
- 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-ambul care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should 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 provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 202
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
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 normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence
following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usu
place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- 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 autho
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 p
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.
4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support nee
will be met by a change of setting to residential and nursing care during the year (excluding transfers between residen
and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not publish
until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use t
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 ov
taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hosp to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not publishe until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use t data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please ref the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure pl by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Pla

2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards me the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

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

Health and Wellbeing Board:	Norfolk
Completed by:	Nick Clinch
E-mail:	nicholas.clinch@norfolk.gov.uk
Contact number:	01603 223329
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No
If no please indicate when the HWB is expected to sign off the plan:	Wed 27/09/2023 << Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	County Councillor	Bill	Borrett	Bill.Borrett.cllr@norfolk.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Chief Executive	Tracey	Bleakley	t.bleakley@nhs.net
	Additional ICB(s) contacts if relevant	Director of Primary Care	Mark	Burgis	mark.burgis@nhs.net
	Local Authority Chief Executive	Chief Executive	Tom	McCabe	tom.mccabe@norfolk.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Executive Director of	Debbie	Bartlett	Debbie.bartlett@norfolk.gov.uk
	Better Care Fund Lead Official	Assistant Director	Nicholas	Clinch	nicholas.clinch@norfolk.gov.uk
	LA Section 151 Officer	Director of Financial	Harvey	Bullen	harvey.bullen@norfolk.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 -->	Commissioning Manager, Social Care & Health Partnership Commissioning	Commissioning Manager	Bethany	Small	bethany.small@nhs.net
	Snr. Commissioning Manager, Social Care & Health Partnership Commissioning	Snr. Commissionin	Christine	Breeze	Christine.Breeze@norfolk.gov.uk

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Norfolk

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£9,157,782	£9,157,782	£9,157,782	£9,157,782	£0
Minimum NHS Contribution	£77,165,711	£81,533,291	£77,165,711	£81,533,291	£0
iBCF	£39,618,564	£39,618,564	£39,618,564	£39,618,564	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£5,554,461	£9,220,405	£5,554,461	£9,220,405	£0
ICB Discharge Funding	£5,441,490	£8,340,076	£5,441,490	£8,340,076	£0
Total	**£136,938,008**	**£147,870,118**	**£136,938,008**	**£147,870,118**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£21,885,907	£23,124,650
Planned spend	£36,699,262	£38,776,438

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£38,087,936	£40,243,713
Planned spend	£51,523,944	£54,440,200

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	185.7	167.8	184.1	192.8

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,472.3	1,441.8
	Count	3443	3370
	Population	225266	225266

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.0%	93.3%	93.0%	92.7%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	574	444

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Norfolk

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabilitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the ' **Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Informed by Op Planning 2023/24 submissions and Provider data. Demand pathway splits based on actuals but only available as P0/P1/P2/P3. Bed-based reablement capacity data is not recorded as step-down or step-up, so all in step down. Capacity forecasts for specialist MH, LD and austim included - note: IC is typically > 4-6 weeks for these. Pathway 3 capacity data aligned to Demand as unable to verify capacity at this time. %s averaged for multiple services, as advised by Isla Rowland. 43 service lines contribute to the capacity data, hence no single LoS or av Hours.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

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

Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	790	854	801	850	826	793	782	854	849	825	737	817
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		3222	3374	3379	3306	3304	3275	3490	3540	3379	3511	3504	3538
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST		2154	2216	2216	2186	2159	2129	2127	2334	2253	2084	2086	2385
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement at home (pathway 1)	85	52	53	51	54	44	67	68	75	53	64	76
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		324	372	324	349	378	375	399	428	481	503	319	376
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST		62	79	71	75	76	77	82	79	85	87	68	78
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)												
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST													
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST													
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)												
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST													
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST													
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)												
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST													
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST													
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	52	57	53	54	54	52	51	57	59	55	48	54
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST		189	211	206	203	203	198	207	221	222	212	174	204
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST		63	70	63	52	52	63	63	70	62	59	60	52
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	6	7	6	6	6	6	6	6	7	6	5	6
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	(pathway 3)	34	55	64	49	52	57	74	64	79	76	86	85
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST		10	11	10	10	8	10	10	11	10	9	10	8

3.2 Demand - Community

Demand - Intermediate Care

Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)												
Urgent Community Response	1651	1835	1681	1977	2075	1764	2033	1936	1946	1980	1676	2066
Reablement at home	272	333	289	274	266	163	280	293	294	92	324	316
Rehabilitation at home												
Reablement in a bedded setting	13	11	11	15	6	15	9	14	19	14	15	13
Rehabilitation in a bedded setting												
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	354	354	354	354	354	354	354	354	354	354	354	354
Reablement at Home	Monthly capacity. Number of new clients.	295	305	295	305	310	300	310	300	310	310	281	310
Rehabilitation at home	Monthly capacity. Number of new clients.	115	132	115	123	134	135	143	156	175	184	117	133
Short term domiciliary care	Monthly capacity. Number of new clients.	45	46	16	28	46	52	72	96	132	132	32	63
Reablement in a bedded setting	Monthly capacity. Number of new clients.	32	32	32	32	32	32	32	32	32	32	32	32
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	189	189	189	183	183	172	213	228	220	220	201	236
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	50	73	80	65	66	73	90	81	96	91	101	99

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint
45%	45%	10%
23%	77%	0%
96%	4%	0%
0%	100%	0%
23%	77%	0%
83%	17%	0%
0%	0%	100%

3.4 Capacity - Community

Capacity - Community

Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	162	162	162	162	162	162	162	162	162	162	162	162
Urgent Community Response	Monthly capacity. Number of new clients.	2973	3068	2988	3028	3144	2860	3057	3008	3068	3059	2880	3063
Reablement at Home	Monthly capacity. Number of new clients.	243	243	243	243	243	243	243	243	243	243	243	243
Rehabilitation at home	Monthly capacity. Number of new clients.	888	916	920	931	889	930	943	889	924	954	929	947
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	32	32	32	78	78	78	78	78	78	78	78	78
Other short-term social care	Monthly capacity. Number of new clients.	37	37	37	37	37	37	37	37	37	37	37	37

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly

ICB	LA	Joint
0%	100%	0%
66%	34%	0%
23%	77%	0%
79%	21%	0%
23%	77%	0%
100%	0%	0%
0%	100%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Norfolk

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Norfolk	£9,157,782	£9,157,782
DFG breakdown for two-tier areas only (where applicable)		
Breckland	£1,329,644	£1,329,644
Broadland	£1,013,705	£1,013,705
Great Yarmouth	£1,348,045	£1,348,045
King's Lynn and West Norfolk	£1,782,807	£1,782,807
North Norfolk	£1,354,615	£1,354,615
Norwich	£1,293,541	£1,293,541
South Norfolk	£1,035,425	£1,035,425
Total Minimum LA Contribution (exc iBCF)	**£9,157,782**	**£9,157,782**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Norfolk	£5,554,461	£9,220,405

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Norfolk and Waveney ICB	£5,441,490	£8,340,076
Total ICB Discharge Fund Contribution	£5,441,490	£8,340,076

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Norfolk	£39,618,564	£39,618,564
Total iBCF Contribution	**£39,618,564**	**£39,618,564**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Norfolk and Waveney ICB	£77,165,711	£81,533,291
Total NHS Minimum Contribution	**£77,165,711**	**£81,533,291**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	
Total NHS Contribution	**£77,165,711**	**£81,533,291**	

	2023-24	2024-25
Total BCF Pooled Budget	**£136,938,008**	**£147,870,118**

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Norfolk

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£9,157,782	£9,157,782	£0	£9,157,782	£9,157,782	£0
Minimum NHS Contribution	£77,165,711	£77,165,711	£0	£81,533,291	£81,533,291	£0
iBCF	£39,618,564	£39,618,564	£0	£39,618,564	£39,618,564	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£5,554,461	£5,554,461	£0	£9,220,405	£9,220,405	£0
ICB Discharge Funding	£5,441,490	£5,441,490		£8,340,076	£8,340,076	£0
Total	**£136,938,008**	**£136,938,008**	**£0**	**£147,870,118**	**£147,870,118**	**£0**

Required Spend

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

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£21,885,907	£36,699,262	£0	£23,124,650	£38,776,438	£0
Adult Social Care services spend from the minimum ICB allocations	£38,087,936	£51,523,944	£0	£40,243,713	£54,440,200	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

60, 61,
62, 63,
64, 65,
66, 67,
68, 69,
70, 71,
72, 73,
74, 75,
76, 77,
78, 79,
80, 81,
82, 83,
84, 85,
86, 87,
88, 89,
90, 91,
92, 93,
94, 95,
96, 97,
98, 99,
100, 101,
102, 103,
104, 105,
106, 107,
108, 109,
110, 111,
112, 113,
114, 115,
116, 117,
118, 119,
120, 121,

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Norfolk Advice Network and Advocacy	Provider: Age UK, Equal Lives. To provide a single point of contact for information,	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		Joint	12.0%	88.0%	Charity / Voluntary Sector	Minimum NHS Contribution
2	A Social Impact Bond for Carers	Provider: Carers Matter Norfolk To support carers to maintain	Carers Services	Carer advice and support related to Care Act duties		2244	2244	Beneficiaries	Social Care		Joint	12.0%	88.0%	Private Sector	Minimum NHS Contribution
9	ICES (Integrated Community Equipment	Provider: Medequip Provides equipment to aid independence at home.	Assistive Technologies and Equipment	Community based equipment		37,450	39322	Number of beneficiaries	Social Care		Joint	92.0%	8.0%	Private Sector	Minimum NHS Contribution
10	Integrated Care Coordinators	Provider: Norfolk County Council. ICC roles work with health and social care	Integrated Care Planning and Navigation	Care navigation and planning					Primary Care		Joint	89.0%	11.0%	Local Authority	Minimum NHS Contribution
20	Norfolk First Response	Provider: Norfolk County Council. Reablement Services offering six weeks	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		6827	6827	Packages	Social Care		Joint	12.2%	87.8%	Local Authority	Minimum NHS Contribution
21	Rapid Response (part of Swifts and Nightowls)	Provider: Norfolk County Council rapid response service for people with short	Urgent Community Response						Social Care		Joint	25.0%	75.0%	Local Authority	Minimum NHS Contribution
51	Caring for Better Outcomes	Provider: NCC Home Support Framework Schemes aimed to increase	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)		380	380	Packages	Social Care		LA			Private Sector	Minimum NHS Contribution
56	District Direct	Provider: District and Borough Councils. Ensures District Council	High Impact Change Model for Managing Transfer of Care	Housing and related services					Acute		Joint	0.3%	99.7%	Local Authority	Minimum NHS Contribution
57	Dementia Support SLA	Support service for people with dementia	Prevention / Early Intervention	Risk Stratification					Social Care		LA			Private Sector	Minimum NHS Contribution
60	Out of hosptial / Short Term offer	Bed based short term offer and hospital social work teams	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	Minimum NHS Contribution
61	Brokerage	Brokerage Team Staff - increased capacity to support placements out of hospital	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution
62	Social Care and Health Partnership Commissioning	Joint Commissioning Team across NCC and the ICB	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution
63	Integrated Quality Team	Joint Quality Team across NCC and the ICB	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution
64	LD, MH and Autism Packages of Care	Care services for people with LD, MH and Autism	Home Care or Domiciliary Care	Domiciliary care packages		138610	138610	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
65	BCF Health and Wellbeing Partnership Funds	Provider: Norfolk's Health and Wellbeing Partnerships. To support place based	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Private Sector	Minimum NHS Contribution
66	Home From Hospital	Provider: British Red Cross Support for patients on discharge to settle them in at	High Impact Change Model for Managing Transfer of Care	Other	Low level post discharge support in the				Social Care		Joint	0.3%	99.7%	Charity / Voluntary Sector	Minimum NHS Contribution
38	Eating Matters	Eating Matters provides counselling in the community for people suffering with mild	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
39	Voluntary Sector MH Services	Dementia support, psychiatric liaison and suicide prevention services provided	Prevention / Early Intervention	Risk Stratification					Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution

40	West Norfolk Carers Project	Independent charity supporting unpaid family carers and providing a carer's	Carers Services	Other	Information, advice and guidance	164	164	Beneficiaries	Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
41	Care Navigators (West Norfolk)	Care Navigators provide support for people to 'navigate' their way around	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
42	Day Centres / Daycare	Marion Road Day (Norwich) Centre & Glaven Day Centre (North Norfolk)	Prevention / Early Intervention	Risk Stratification					Primary Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
43	Wellfamily Services (West Norfolk)	Well Family is a one-stop health and wellbeing service comprising a suite of health-	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
44	St. Martin's Hub	Provides emergency accommodation and support for rough sleepers in	Housing Related Schemes						Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
45	West Norfolk Disability Information	Provides a range of information and support to individuals with disabilities,	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
46	GP / Medical cover - Int Care Beds (West	GP medical cover to bed-based intermediate care services to help people	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as	Medical cover for IC beds				Primary Care		NHS			Private Sector	Minimum NHS Contribution
47	ASD / ADHD / Asperger's Support	ASD, ADHD and Asperger's support service offers assistance for individuals	Integrated Care Planning and Navigation	Care navigation and planning					Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
48	Transport Plus	Provides transport to enable access to health, social care and wellbeing services using	Community Based Schemes	Other	Transport				Other	Transport service to faciliate attendence at	NHS			Local Authority	Minimum NHS Contribution
49	West Norfolk Community Action Norfolk	CAN is the leading organisation for engagement with the voluntary,	Enablers for Integration	Voluntary Sector Business Development					Primary Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
50	West Norfolk Community Transport	Provides day to day management of a bank of drivers, including recruitment	Community Based Schemes	Other	Transport				Other	Management of a community transport scheme	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
64	LD, MH and Autism Packages of Care	Care services for people with LD, MH and Autism. Number of placements dependent on	Residential Placements	Other	LD / MH / Autism residential care	0	0	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
36	SOS Buses - Kings Lynn and Norwich	The SOS buses provide a first point of contact, support and first aid to people who are	Prevention / Early Intervention	Risk Stratification					Other	Mobile service offering integrated	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
3	Community Nursing and Therapy (CN&T)	Community nurses, therapists and clinical support staff provide physical	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
4	Dementia / Alzheimer's Support Service	DSS is a three tier step-up / down system providing: Information, Advice &	Integrated Care Planning and Navigation	Care navigation and planning					Mental Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
5	Great Yarmouth Early Help hub	The GY Early Help Hub is multi-agency model with 20+ system partners supporting	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		NHS			Local Authority	Minimum NHS Contribution
7	HomeWard (Norwich)	HomeWard provides urgent short term care, nursing and therapy support. The MDT	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		24	24	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
8	Rapid Assessment Team (RATS) & Virtual Ward	West Virtual Ward provides short-term care/support to enable individuals who have	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		30	30	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
90	Independent Mental Health Advocacy and	Independent Mental Health Advocacy and Independent Mental Capacity Advocate	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution
37	Social Prescribing	A community wellbeing service that focus' on improving wellbeing. A free	Prevention / Early Intervention	Social Prescribing					Social Care		NHS			Private Sector	Minimum NHS Contribution

11	Intermediate Spot Purchase Beds	Accomodation based commissioning.	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		306	306	Number of Placements	Community Health		NHS			Private Sector	Minimum NHS Contribution
12	Equipment at home (BOC)	Provides oxygen supply (cylinder/concentrator/liquid) and maintains oxygen	Assistive Technologies and Equipment	Community based equipment		0	0	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution
13	Community Access Team (CAT)	CAT manages transfers of care into NCHC's intermediate care units for	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
14	Medical Loans Service	Provider: British Red Cross. Short term loans of equipment to aid	Assistive Technologies and Equipment	Community based equipment		4861	4861	Number of beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
22	Sensing Change	Social work practice providing a range of services including social work,	Prevention / Early Intervention	Risk Stratification					Social Care		NHS			Local Authority	Minimum NHS Contribution
16	Norfolk Medicines Support Service (NMSS)	NMSS supports vulnerable individuals with practical, user-friendly solutions to	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			Local Authority	Minimum NHS Contribution
17	Equal Lives	A disability rights organisation supporting people to empower	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		NHS			Local Authority	Minimum NHS Contribution
18	Norfolk Volunteer Services	Encourages and enables people to use their time, skills and talents to volunteer	Enablers for Integration	Voluntary Sector Business Development					Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
19	Palliative Beds & Hospice (West Norfolk)	Provision of specialist palliative and end of life care to people living with life-	Residential Placements	Nursing home		225	225	Number of beds/Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
51	Learning Disability Beds	Accomodation-based CHC commissioning. Difficult to calculate give the varied	Residential Placements	Learning Disability		0	0	Number of beds/Placements	Community Health		NHS			Private Sector	Minimum NHS Contribution
24	Weight Management Scheme	Scheme to support people at risk of further health conditions due to their	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Private Sector	Minimum NHS Contribution
26	Neuro Cardiac & Pulmonary Support Services	Specialist community nurses providing neurological, cardiac & pulmonary support	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
27	Specialist Nursing Teams	Specialist Nursing Teams to support people in the community	Personalised Care at Home	Physical health/wellbeing					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
28	Mid Norfolk Heartwork	Heartwork provides a structured, supervised exercise scheme enabling	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
29	Norfolk and Norwich SEND (Special	The Special Educational Needs and Disabilities (SEND) Support scheme provides	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
30	Dementia/Alzheimer's Support Nurses	Specialist dementia nurses who give expert practical, clinical and emotional	Personalised Care at Home	Mental health /wellbeing					Mental Health		NHS			Local Authority	Minimum NHS Contribution
30	Norfolk Deaf Association	Norfolk Deaf Association (NDA) delivers community-based support to individuals	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
31	Community Stroke Support (West)	Provides a range of community stroke support services in the West:	Prevention / Early Intervention	Risk Stratification					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
32	Together	Service for people with serious mental health problems provided by	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Mental Health		NHS			Local Authority	Minimum NHS Contribution
33	NEAT	Network of Escalation Avoidance Teams - NEAT is a single, multi-agency point of	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Other	Integrated Urgent response team	NHS			Local Authority	Minimum NHS Contribution

34	Discharge Practitioner Services	Funding of practitioners to support multi-agency discharge teams.	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		NHS			Local Authority	Minimum NHS Contribution
35	Staff recharges - GP's & Ass. Practitioners	Primary care support focused on healthier communities, better healthcare for people	Prevention / Early Intervention	Risk Stratification					Primary Care		NHS			Local Authority	Minimum NHS Contribution

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 2. Digital participation services 3. Community based equipment 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 2. Safeguarding 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 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 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) 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 2. Discretionary use of DFG 3. Handyperson services 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. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 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. 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 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	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 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 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 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 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. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
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) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 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) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 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 2. Physical health/wellbeing 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 2. Risk Stratification 3. Choice Policy 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 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 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 and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Norfolk

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	178.7	158.4	175.1	173.1	2022/23 FY baseline. Seasonality applied linked to operational planning submission.	Multi-disciplinary teams focus on providing an Urgent Community response, coordinating services around an individual to avoid hospital admission in a crisis.
	Number of Admissions	2,140	1,897	2,096	-		
	Population	907,760	907,760	907,760	907,760		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	185.7	167.8	184.1	192.8		

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,636.9	1,472.3	1,441.8	2022/23 local data uplifted to match national data in line with 2021/22. Linked to operational planing submission	In 2023-24, the initial falls activity is being consolidated under a single NW ICS Falls Programme, with three workstreams •Acute and Inpatient settings •Community, including VCSE •Care Homes. The overall aim is to provide cohesive falls prevention and response pathways, using all relevant system partner resources to 'tip
	Count	3,835	3,443	3,370		
	Population	225,266	225,266	225,266		

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

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
	Quarter (%)	91.8%	93.1%	92.8%	91.9%	2022/23 FY baseline. Seasonality applies, linked to operational planning submission.	A number of long standing services including the Home from Hospital service, has been recommissioned with pro-ident
	Numerator	16,844	16,650	17,172	19,043		

Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Denominator	18,341	17,875	18,508	20,722		have been recommissioned with providers coming together to provide a cohesive offer across the County, to better support people in their own homes following discharge from hospital
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	92.0%	93.3%	93.0%	92.7%		
	Numerator	17,942	17,721	18,295	18,510		
	Denominator	19,496	18,988	19,671	19,965		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	574.2	607.3	520.2	444.5	We have achieved significant reduction in 22/23 as a result of changed ways of working. As we continue to embed these changes, the expect to see further reduction in admissions to residential and nursing.	New ways of working, focussing on increased offer on home care and early prevention work through our connecting communities programme of work and community discharge support offer, will continue to be rolled out across all areas,
	Numerator	1,294	1,416	1,213	1,053		
	Denominator	225,343	233,182	233,182	236,901		

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

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.9%	86.5%	85.7%	85.0%	The reablement service has broadened its criteria to include more people with more complex needs. This accounts for the increase in denominator for 22-23 and the slight expected increase for 23-24. However, this also means a likely reduction	Targets in place to increase workflow into reablement, partially due to changing of access criteria.
	Numerator	481	485	508	510		
	Denominator	560	561	593	600		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.