Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

1. Guidance for Quarter 2

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

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

Note on entering information into this template

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

Data needs inputting in the cell
Pre-populated cells
Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%.
Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

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

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

Checklist (2. Cover)

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

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

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

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

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

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

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

4. Metrics

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

Plans for these metrics were agreed as part of the BCF planning process.

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

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

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

You should also include narratives for each metric on challenges and support needs, as well as achievements.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

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

5. Capacity & Demand Refresh

Please use this section to update both capacity and demand (C&D) estimates for the period November 2023 to March 2024.
This section is split into 3 separate tabs:

5.1 C&D Guidance & Assumptions

Contains guidance notes including how to calculate demand/capacity as well as 6 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs and ongoing data issues.

5.2 C&D Hospital Discharge

Please use this section to enter updated demand and capacity related to Hospital Discharge in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. expected capacity and demand from your original planning template has been populated for reference. If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

In Capacity and Demand plans for 2023-24, areas were advised not to include capacity you would expect to spot purchase. This is in line with guidance on intermediate care, including the new Intermediate Care Framework. However, for this exercise we are collecting the number of packages of intermediate/short term care that you expect to spot purchase to meet demand for facilitated hospital discharge. This is being collected in a separate set of fields. You should therefore:

- record revised demand for hospital discharge by the type of support needed from row 30 onwards
- record current commissioned capacity by service type (not including spot purchasing) in cells K22 to O26
- record the amount of capacity you expect to spot purchase to meet demand in cells P22 to T26.

Spot purchased capacity should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 C&D Community

Please use this section to enter updated demand and capacity related to referrals from community sources in the bottom two tables. The table at the top then calculates the gap or surplus of capacity using the figures provided. The same period's figures has been extracted from your planning template for reference.

If estimates for demand and/or capacity have not changed since your original plan, please re enter these figures in the relevant fields (i.e. do not leave them blank).

Data from assured BCF plans has been pre-populated in tabs 5.2 and 5.3. If these do not match with your final plan, please let your BCM and the national team know so that we can update out records and note the discrepancy in your response to question 1 on tab 5.1. Enter your current expected demand and capacity as normal in tabs 5.2 and 5.3.

HM Government

NHS England

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

2. Cover

Version 3.0

Please Note:

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

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

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

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

		Checklist Complete:
Health and Wellbeing Board:	Stockton-on-Tees	Yes
Completed by:	Yvonne Cheung	Yes
E-mail:	yvonne.cheung@stockton.gov.uk	Yes
Contact number:	1642524577	Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes	Yes
If no, please indicate when the report is expected to be signed off:		Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5.1 C&D Guidance & Assumptions	Yes
5.2 C&D Hospital Discharge	Yes
5.3 C&D Community	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Stockton-on-Tees

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	

Confirmation of National Conditions

National Conditions	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:	Checklist Complete:
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 2 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Stockton-on-Tees

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

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

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

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4					
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	295.0	269.0	307.0	288.0	297.7	Not on track to meet target	No specifc challenges or support needs. The Q1 performance is only slightly over plan.	We continue to aim to meet the ambition through our BCF funded admission avoidance and prevention schemes as well as wider initiatives such as UCR, Ageing Well and Hospital @ Home.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	93.4%	93.4%	93.4%	93.4%	92.35%	Not on track to meet target	No specifc challenges or support needs. The Q1 performance is only slightly below plan and remains high in comparison to other localities.	We have several schemes and initiatives in already place to support this metric and several others funded via the 23/24 Discharge Fund which are due to commence and should impact on performance.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,782.0	401.7	On track to meet target	No specifc challenges or support needs.	On track to meet the target, and a review of falls services both proactive and reactive has commenced across the Tees Valley which should support this metric.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				434		Not on track to meet target	Ageing population, complexity and acuity of clients lead to higher level of needs combined with deconditioning caused by COVID lockdowns	Based on LA SALT return as per ASCOF Definition there were 59 Admissions within the Q1 2023-24period equating to a 159.7 per 100,000 population aged 65 and over. This is a slight increase on the Q1 period for	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				91.4%		Not on track to meet target	Ageing population, complexity and acuity of the clients influence their abilities to remain at home.	Based on ASCOF data, Q1 position is reported at 88.4% against a target of 91.4%. Work continues to meet this challenge.	Yes

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Stockton-on-Tees

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include how learning from the last 6 months was used to arrive at refreshed projections? * We are unable to split Pathway 0 discharges for those who require some social support, therefore as per guidance have not reported P0 discharges at all. * We previously reported P0 capacity as 0 as we did not collect capacity for these services. Although we still cannot quantify all P0 (Social Support) capacity, we have started to report the services that we can (Home but Not Alone - Hospital Discharge Service, Home From Hospital (Five Lamps)). * We have introduced a method of collecting and monitoring discharges (OPTICA) via the Trust (North Tees), therefore for this refresh we are using this data for the majority of the projected demand rather than the annual plans and proportional pathway splits that we previously used. This system is not yet fully functional in other acute Trusts, therefore we must continue with previous data sources for these. * The refresh of the data shows that activity into the P2 spot beds has slightly decreased, however there has been better use of the core commissioned intermediate care facility which meanst the overall demand remains static. Given that this refresh is for the winter period, we have looked at previous activity and can see that, on average, an additional 5 beds per week are usually required at this time, therefore this has also been built into the figures. These figures take into account LOS and occupancy levels. * The information used to complete this capacity and demand refresh is the same source as we used to complete the Community Bed Audit/Trajectory.	Yes
2. Please outline assumptions used to arrive at refreshed projections (including to optimise length of stay in intermediate care and to reduce overprescription of care). Please also set out your rationale for trends in demand for the next 6 months (e.g how have you accounted for demand over winter?) **Demand:** The original BCF Demand plan was based on historical trends which included an increase in activity over Winter. We are using more accurate data now to project demand for Nov-Mar (as mentioned above), therefore have made some assumptions for Winter. For example we can see that historically we use an average of 5 more beds per week, so have built this into the demand plans. As we use a spot purchase arrangement, in addition to the Core bedded intermediate care facility (block), we have the option to flex the capacity to allow for this, providing finances and care home capacity allow. As we do not have the historical P1 data in the format we are now using to project demand, if it difficult to predict what effect winter will have.	Yes
Capacity: The original BCF capacity plan was based on historical trends which included a higher demand over the winter period. We also modelled the capacity based on the predicted impact of additional schemes developed to support community and hospital discharge pathways. Therefore the refreshed projections reflect the most recent data rather than any significant changes to commissioned services.	Yes
3. What impact have your planned interventions to improve capacity and demand management for 2023-24 had on your refreshed figures? Has this impact been accounted for in your refreshed plan? * Although there are still developments underway, our plans and implementation of the new OPTICA system in Stockton and Hartlepool have helped us to gather more accurate data on discharges on each of the pathways. The development of the community module of the same system will only improve this further as we continue to understand what the data tells us. * We have considered the schemes funded within the Market Sustainability Improvement Plan and whilst they will have a positive impact on sustaining the market and retaining the workforce they don't impact on the refreshed Capacity and Demand figures * We have also considered and are beginning to address via recently established local partnership working groups the priority areas set out in the recently published Intermediate care framework in particular 'Priority area 1: Improve demand and capacity planning.' We are in discussion with colleagues to address the 'Recommended Action (now until March 2025): Develop a single approach to ICS demand and capacity planning for intermediate care across BCF and NHS planning footprints.'	Yes
4. Do you have any capacity concerns or specific support needs to raise for the winter ahead? * We feel it pertinent to reiterate here the resource needed to complete the numerous templates required for submission, which will continue to pull on valuable resource over winter.	Yes
5. Please outline any issues you encountered with data quality (including unavailable, missing, unreliable data). *As previously mentioned, our data does not include capacity and demand for Mental Health services. Since the last submission we have begun conversations with TEWV (Mental Health Trust) in relation to this, and to consider what should be collected in the future, however are not in a position to include it this time. * We continue to use a spot purchase model when our core 'block' beds cannot be used (i.e. full, daily admissions met, Assistance of 2s limit reached). This offers a certain flexibility in terms of capacity and demand. If external factors allow (finances, capacity) we flex this capacity to meet the demand, whether thats an increase or decrease. We are continuing to monitor this carefully, especially in light of measures we have put in place to get people 'home first' and decrease the dependancy on beds. * Although the demand data we are now using is more accurate than previous submissions, it is a new data source and recording mechanism, therefore we expect that this will not be faultless and the data provided gives an overall impression rather than perfect numbers.	Yes
6. Where projected demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge? On the whole we think that our capacity and demand are relatively well matched, and this is backed up with the data provided (note - the beds data appears to show that we do not have enough capacity for community/step up and that we have surplus discharge capacity, however we commission as a whole therefore this should be looked at as a whole). We have a number of schemes in progress and in development which will affect/shift the demand between pathways and we will be monitoring this closely. Examples of these are a review of our Intermediate Care pathways as a whole which includes a review of the core (block) beds including admission criteria and additional wraparound services commissioned via the Hospital Discharge Fund both in the acute trust and in the community. We actively monitor the demand for our services and where there are spikes in demand, the capacity is increased accordingly. For example we have the mechanism to increase the number of beds which are available via spot purchasing or can increase the number of hours provided by our Dom Care providers. There are, however, limitations to this, not only around financial constraints but also staff recruitment and retention.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and question & answer document

5.1 Assumptions

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6/7 months of the year
- modelling and agreed changes to services as part of Winter planning or following the Market Sustainability and Improvement Fund announcement
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

5.2 and 5.3 Summary Tables

The tables at the top of the next two tabs show a direct comparison of the demand and capacity for each area, by showing = (capacity) – (demand). These figures are pre-populated from the previous template as well as calculating new refreshed figures as you complete the template below. **Negative figures show insufficient capacity and positive figures show that capacity exceeds demand.**

5.2 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record their refreshed expectations of monthly demand for supported discharge by discharge pathway.

Data from the previous capacity and demand plans will be auto-populated, split by trust referral source. You will be able to enter your refreshed number of expected discharges from each trust alongside these. The first table may include some extra rows to allow for areas who are recording demand from a larger number of referral sources. If this does not apply to your area, please ignore the extra lines.

This section in the previous template asked for expected demand for rehabilitation and reablement as two separate figures. It was found that, by and large, this did not work well for areas so the prepopulated figures for these service types have been combined into one row. Please enter your refreshed expectations for rehabilitation and reablement as one total figure as well.

Virtual wards should not be included in intermediate care capacity because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, please select the relevant trust from the list.

From the capacity and demand plans collected in June 2023, it emerged that some areas had difficulty with estimating demand and capacity for Pathway 0 (social support). By social support, we are referring to lower level support provide outside of formal rehabilitation and reablement or domiciliary care. This is often provided by the voluntary and community sector. Demand estimates for this service type should only include discharges on Pathway 0 that require some level of commissioned low-level support and not all discharges on Pathway 0. If it is not possible to estimate figures in relation to this please put 0 rather than defaulting to all Pathway 0 discharges.

5.2 Capacity - Hospital Discharge

This section collects refreshed expectations of 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) (pathway 0)
- Reablement & Rehabilitation at home (pathway 1)
- Short term domiciliary care (pathway 1)
- Reablement & Rehabilitation in a bedded setting (pathway 2)
- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

The recently published Intermediate Care Framework sets out guidance on improving capacity, and use of this capacity. You should refer to this in developing your refreshed BCF Capacity and Demand plans.

As with the 2023-24 template, 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 Length of Stay where there are significant outliers.

Peak Occupancy (percentage) - What was the highest levels of occupancy 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.

The template now asks for the amount of capacity you expect to secure through spot purchasing. This should be capacity that is additional to the main estimate of commissioned/contracted capacity (i.e. the spot purchased figure should not be included in the commissioned capacity figure). This figure should represent capacity that your local area is confident it can spot-purchase and is affordable, recognising that it may impact on people's outcomes and is unlikely to be best value for money and local areas will be working to reduce this area of spend in the longer term.

5.3 Demand - Community

This section collects refreshed expectations of demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. As with the previous template, referrals are not collected 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 2023-25 Planning Requirements.

The units can simply be the number of referrals.

As with all other sections, figures from the 2023-24 template will be auto-populated into this section.

5.3 Capacity - Community

This section collects refreshed expectations of capacity for community services. You should input the expected available capacity across health and social care for different service types. As with the hospital discharge sheet, data entered in the assured BCF plan template has been prepopulated for reference. 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 these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Please see the guidance on 'Demand – Hospital Discharge' for information on why the capacity and demand estimates for rehabilitation and reablement services is now being collected as one combined figure. 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 Length of Stay where there are significant outliers.

"Peak Occupancy (percentage) - What was the highest levels of occupancy 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."

Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Stockton-on-Tees

Hospital Discharge	Previous plan					Refreshed capacity surplus. Not including spot purchasing					Refreshed capacity surplus (including spot puchasing)				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	-1564	-1652	-1586	-1453	-1708	75	75	75	75	75	75	75	75	75	75
Reablement & Rehabilitation at home (pathway 1)	-13	-35	-18	-4	-21	51	36	44	29	30	51	36	44	29	30
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	-21	-47	-40	-42	-36	-22	-21	-21	-23	-21	18	20	20	16	20
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-28	-22	-30	-22	-42	-10	-9	-9	-10	-9	3	4	4	2	4

Capacity - Hospital Discharge		Prepopulated from plan:					Refreshed planned capacity (not including spot purchased capacity					Capacity that you expect to secure through spot purchasing				
Service Area	**Metric**	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	Monthly capacity. Number of new clients.	0	0	0	0	0	75	75	75	75	75	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new clients.	121	106	114	99	100	121	106	114	99	100	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new clients.	73	76	76	71	76	25	26	26	24	26	40	41	41	39	41
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new clients.	8	8	8	8	8	7	8	8	7	8	13	13	13	12	13

Demand - Hospital Discharge		Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Pathway	**Trust Referral Source**	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS) (pathway 0)	**Total**	**1564**	**1652**	**1586**	**1453**	**1708**	**0**	**0**	**0**	**0**	**0**
	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	1420	1508	1440	1316	1564	0	0	0	0	0
	OTHER	144	144	146	137	144	0	0	0	0	0
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Reablement & Rehabilitation at home (pathway 1)	**Total**	**134**	**141**	**132**	**103**	**121**	**70**	**70**	**70**	**70**	**70**
	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	111	118	109	81	98	55	55	55	55	55

Checklist

Complete:

Yes
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	OTHER	23	23	23	22	23	15	15	15	15	15	Yes
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Short term domiciliary care (pathway 1)	**Total**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	Yes
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Reablement & Rehabilitation in a bedded setting (pathway 2)	**Total**	**94**	**123**	**116**	**113**	**112**	**47**	**47**	**47**	**47**	**47**	Yes
	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	91	120	113	110	109	45	45	45	45	45	Yes
	OTHER	3	3	3	3	3	2	2	2	2	2	Yes
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Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	**Total**	**36**	**30**	**38**	**30**	**50**	**17**	**17**	**17**	**17**	**17**
	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	26	20	28	21	40	12	12	12	12	12
	OTHER	10	10	10	9	10	5	5	5	5	5
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Better Care Fund 2023-24 Capacity & Demand Refresh

5. Capacity & Demand

Selected Health and Wellbeing Board: Stockton-on-Tees

Community	Previous plan					Refreshed capacity surplus:				
Capacity - Demand (positive is Surplus)	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	0	0	0	0	0	0	0	0	0	0
Reablement & Rehabilitation at home	14	26	34	17	36	14	26	34	17	36
Reablement & Rehabilitation in a bedded setting	-6	-6	-6	-6	-6	-5	-5	-5	-5	-5
Other short-term social care	6	6	6	6	6	6	6	6	6	6

Capacity - Community		Prepopulated from plan:					Please enter refreshed expected capacity:					Checklist
Service Area	Metric	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Complete:
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	Yes
Urgent Community Response	Monthly capacity. Number of new clients.	78	99	56	36	34	78	99	56	36	34	Yes
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	26	38	47	29	48	26	38	47	29	48	Yes
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	4	4	4	4	4	5	5	5	5	5	Yes
Other short-term social care	Monthly capacity. Number of new clients.	6	6	6	6	6	6	6	6	6	6	Yes

Demand - Community	Prepopulated from plan:					Please enter refreshed expected no. of referrals:				
Service Type	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	78	99	56	36	34	78	99	56	36	34
Reablement & Rehabilitation at home	12	12	13	12	12	12	12	13	12	12
Reablement & Rehabilitation in a bedded setting	10	10	10	10	10	10	10	10	10	10
Other short-term social care	0	0	0	0	0	0	0	0	0	0

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes