

Further guidance for completing Expenditure

National Conditions 2 & 3

Schemes tagged with the following will count towards the

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, o
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

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

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

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

15	Prevention / Early Intervention
16	Residential Placements
18	Other

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ne planned **Adult Social Care services spend** from the NHS min:

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planned **Out of Hospital spend** from the NHS min:

only the NHS % will contribute)

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Sub type
<ul style="list-style-type: none">1. Telecare2. Wellness services3. Digital participation services4. Community based equipment5. Other
<ul style="list-style-type: none">1. Carer advice and support2. Independent Mental Health Advocacy3. Safeguarding4. Other
<ul style="list-style-type: none">1. Respite Services2. Other
<ul style="list-style-type: none">1. Integrated neighbourhood services2. Multidisciplinary teams that are supporting independence, such as anticipatory care3. Low level support for simple hospital discharges (Discharge to Assess pathway 0)4. Other

1. Adaptations, including statutory DFG grants
2. Discretionary use of DFG - including small adaptations
3. Handyperson services
4. Other

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

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

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

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

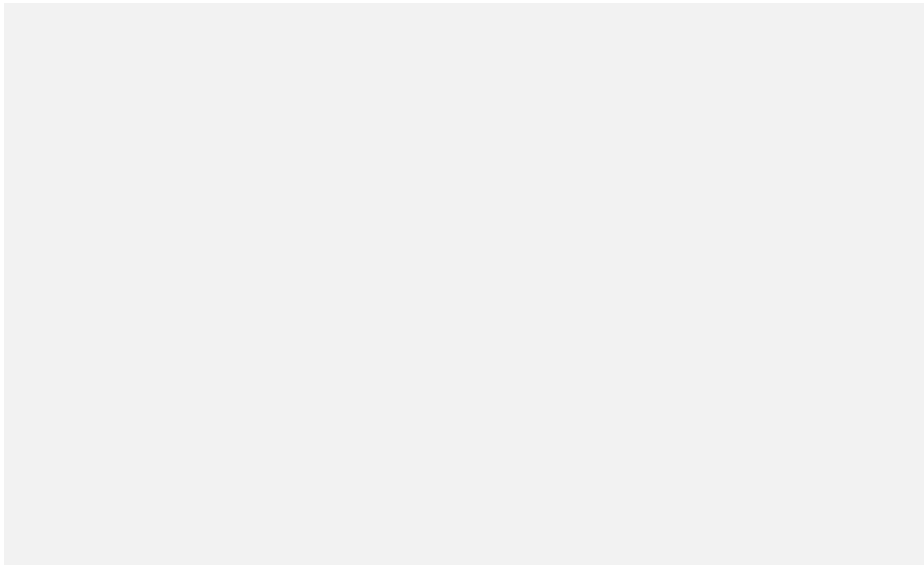
1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

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

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

1. Social Prescribing
2. Risk Stratification
3. Choice Policy
4. Other

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



Description
<p>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).</p>
<p>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.</p>
<p>Supporting people to sustain their role as carers and reduce the likelihood of crisis.</p> <p>This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.</p>
<p>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)</p>
<p>Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'</p>

The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.

The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes.

Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.

A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.

This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals.

Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams.

Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.

Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

Provides support in your own home to improve your confidence and ability to live as independently as possible

Various person centred approaches to commissioning and budgeting, including direct payments.

Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.

Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.

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